

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35158

STATE FILE NUMBER

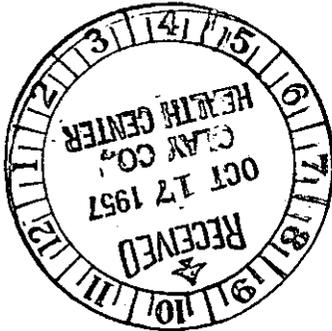
FILED OCT 21 1957

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Excelsior Springs, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sharp's Nursing Home</u>			Length of stay in lb <u>3 yrs</u>			d. STREET ADDRESS (If outside, give location) <u>101 Linden</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1957</u>					
3. NAME OF DECEASED (Type or print) First <u>Hiram</u> Middle <u>Calvin</u> Last <u>O'Dell</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9 1876</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>	
100. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (City and state or country) <u>Baldwell Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John O'Dell</u>				14. MOTHER'S MAIDEN NAME <u>Frances Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Graver O'Dell, Excelsior Springs, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Oct. 10, 1954</u> to <u>Sept. 25, 1957</u> and last saw her alive on <u>Sept. 25, 1957</u> Death occurred at <u>Sept. 26, 1957 7:45 a. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Regene B. Kobchansky, M.D.</u>				22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>9/27/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-28-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW NEW GARDEN</u>		23d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO</u>	
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>				25. DATE RECD. BY LOCAL REG. <u>9-28-57</u>		26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>	
Excelsior Springs, Missouri (Licensed Embalmer's Statement on Reverse Side)							

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Lindley Jarman*

Licensed Embalmer No. *458*
Excelsior Springs
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.