N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Putnam

Township Medacine

or

Village

or

City (NO. St.: Ward)

Registration District No. 717 File No. 2122-A.

Primary Registration District No. 5946 Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Alice Mary Overstreet

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem.

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): yes

DATE OF BIRTH: March (Month) 8th (Day), 1858 (Year)

AGE: 56 yrs. 10 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Putnam Co Ohio

PARENTS
NAME OF FATHER: Wm Houser
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Elizabeth Rumbau
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A O Overstreet

(ADDRESS) Lucerne Mo

Filed Jan 27th 191__ F D Rice REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: January (Month) 26 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1914, to Jan 26th, 1915, that I last saw her alive on Jan 26th, 1915, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

84 Apoplexy 64
77

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Artero Sclerosis

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) O C Kilbourne M. D.

Jan 26 1915 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Bushy cemetry

DATE OF BURIAL: 1-27 1915

UNDERTAKER: J Lee Hawk

ADDRESS: Lucerne Mo

Held up on account of family history FDR

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO..... .....St.:.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.