

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

Do not use this space.
Carlsbad 2216
File No. _____
Registered No. 12 St. _____ Ward)

20 1930

1. PLACE OF DEATH

County *Pettis*
Township *Praine*
City *Sedalia* (No. _____)

Registration District No. *668*
Primary Registration District No. *5890*

2. FULL NAME

Gertrude Lucile Overmier

(a) Residence. No. *R 7 P H 6* St. _____ Ward. _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 28 1898*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
31 8 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Mo*

PARENTS

10. NAME OF FATHER *Phil Newton*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Mary Smith*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

14. INFORMANT *Ernest Overmier*

(Address) *Sedalia Mo*

15. FILED *1-14-36* *J.S. Love*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 10 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 5 1930* to *Jan 10 1930*, that I last saw her alive on *Jan 10 1930*, and that death occurred, on the date stated above, at *12:45 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
2 3/4 (duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) *Surgical Tuberculosis*
(duration) yrs. 2 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *General findings*

(Signed) *Jno B Carlsbad* M. D.

1/10 1930 (Address) *Sedalia Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Crown Hill

DATE OF BURIAL

1/12 1930

20. UNDERTAKER

Lillipie

ADDRESS

Sedalia

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.

