WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

AUG 14 1934

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

Do not use this space.

File No. 25129

Registered No.

1. PLACE OF DEATH
County: Jasper
Township:
City: Joplin (No. Freeman Hosp., St. Ward)
Registration District No. 411
Primary Registration District No. 2002

2. FULL NAME: Leslie Alvin Overall
(a) Residence, No. Webb City, Mo. 83 West 3rd St.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): February 7, 1920

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
14	5	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Student
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sarcoxie, Missouri

FATHER
13. NAME: Herman L. Overall
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Aurora, Missouri

MOTHER
15. MAIDEN NAME: Alta ~~Belle~~ Musk
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Washburn, Missouri

17. INFORMANT: H. L. Overall
(ADDRESS) Webb City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Sarcoxie Cemetery DATE: July 30, 1934

19. UNDERTAKER: Glen C. Cale
(ADDRESS) Sarcoxie, Missouri

20. FILED: 7-31, 1934 Ed D. Jones, Registrar.

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 28, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 27, 1934, to July 28, 1934
I last saw him alive on July 28, 1934. Death is said to have occurred on the date stated above, at 9:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
1. Fractured Cervical Vertebra	July 14
2. Osteomyelitis of skull	3?
3. Meningitis Bacillar non epidemic	July 27
4. Abscess of scalp.	July 24

Other contributory causes of importance:
154
104 B
79 A 1. Fractured cervical vertebra.

Name of operation: Osteotomy of skull Date of July 28
What test confirmed diagnosis? X Ray — Was there an autopsy? No
Comatose — Physical findings

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Winfield Scott, M. D.
(Address) Freeman Hosp., Joplin, Mo.

#2 Jasper Joplin

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Leslie Alvin Overall

Who died at _____ on July 28, 1934

Residence: No. _____ St. _____

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, ~~married, widowed or divorced:~~ _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

154

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Frontal Sinusitis, Osteomyelitis of skull, Meningitis, Basal or non-epidemic, Abscess Scalp. No injury - non-tubercular

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Ed W. James Date filed 7-31-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh M.D.

Special Agent.

Reg. Dist. No. 411

Primary Reg. Dist. No. 2002

5-25129