

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

19889
Do not use this space.

JUN 20 1939

1. PLACE OF DEATH

(a) County Saline Registration District No. 796
(b) Township _____ Primary Registration District No. 3038
(c) City Marshall (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Lucy Overley
(a) Residence, No. 553 West Jackson St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 27, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 2 3

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

12. BIRTHPLACE (CITY OR TOWN) Saline County 0
(STATE OR COUNTRY) Missouri 1

FATHER 13. NAME Noah Groves 1

14. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Virginia

MOTHER 15. MAIDEN NAME Elizabeth Myrtle

16. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Thomas M. Overley
Marshall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Olive Cem. DATE June 1 1939

19. FUNERAL DIRECTOR (NAME) Campbell-Lewis
(ADDRESS) Marshall, Mo.

20. FILED 5-31-39 Mary Kent
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30, 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 25 to May 30 1939
last saw her alive on May 30 1939. Death is said to have occurred on the date stated above, at 7:52 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic
Intestinal Angitis 1934
Date of onset

Other contributory causes of importance: Hypertension 1937

Name of operation _____ Date of _____
What test confirmed diagnosis? Chronic as there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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 _____, M. D.
(Signed) William
(Address) Marshall Mo.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6/8/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Jan. H. Lewis*
Licensed Embalmer No. *1171*
P. O. Address *Marshall 7*

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 this body is not embalmed, above space should be left blank.