

REC'D SEP 19 1939

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

29826
Do not use this space.

1. PLACE OF DEATH
 (a) County Stodaway Registration District No. 625
 (b) Township _____ Primary Registration District No. 3031 Registered No. 120
 (c) City Maryville (d) Street No. St. Frances Hospital 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.
 165 Unnamed Child

2. PRINT FULL NAME _____
 (a) Residence, No. _____ 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 28 1934

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, or ... hrs. or ... min. |
|--------|----------|----------|----------|---|
| | <u>5</u> | <u>7</u> | <u>2</u> | <u>10</u> min. |

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryville Mo

FATHER

13. NAME Don A Overman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parnell

MOTHER

15. MAIDEN NAME Dorris Holmes
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bedford Iowa

17. INFORMANT Miriam Davis
 (ADDRESS) Maryville

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Parnell DATE Aug. 29 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. Ross
Madame Parnell

20. FILED 8-28 1939 Mamie E. Clardy
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 28 1939

22. I HEREBY CERTIFY, That I attended deceased from 8/28, 1939, to 8/28, 1939
 I last saw him alive on 8/28, 1939 Death is said to have occurred on the date stated above, at 30 m.
 The principal cause of death and related causes of importance were as follows:
Premature 5 months
The mother was operated
8/27 Ruptured appendix
 Date of onset _____

Other contributory causes of importance: 154

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

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? _____
 If so, specify _____
 (Signed) E. E. Cooney M. D.
 (Address) Stodaway Co Health Dept
555

RECEIVED

District Health Officer No. 11;

District File No. *939-1207*

Date Filed *SEP 12 1939*

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

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