DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29107

FILED SEP 18 1941

Registration District No. 689

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Louisiana C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Pike Co Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether
In this community: 2 hrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Pike
(c) City or town: Rural - Hartford township
(If outside city or town limits, write "RURAL")
(d) Street No.: New Hartford Post Office
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Ada Overton

8. (b) If veteran, name war: ____ 8. (c) Social Security No.: ____

4. Sex: Female 5. Color or race: Negro 6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Sherman Overton 6. (c) Age of husband or wife if alive: 40 years

7. Birth date of deceased: 2 (Month) - 27 (Day) - 03 (Year)

8. AGE: Years 38 Months 6 Days 3 If less than one day ____ hr. ____ min.

9. Birthplace: Lincoln Co (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Frank Chapman
13. Birthplace: Lincoln Co (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Cora Willis
15. Birthplace: Lincoln Co (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's ~~own~~ signature: Mary Barnett
(b) Address: Bowling Green Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-7-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Fairview Cem

18. (a) Signature of funeral director: Grace Bankhead
(b) Address: Bowling Green Mo

19. (a) 8/6/41 (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 5th year 1941 hour 6:00 minute P.M.

21. I hereby certify that I attended the deceased ~~from~~ ON AUG 5, 1941, to ____, 19____; that I last saw h. E.R. alive on AUG 5, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
ECLAMPSIA	
Due to: PREVIOUS DAMAGE FROM PREGNANCY	
Due to:	
Other conditions: PREGNANCY (Include pregnancy within 3 months of death) 8 MONTHS	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: W. Bullock (M. D. or other)
Address: Bowling Green Mo Date signed: 8-5-41

(Licensed Embalmer's Statement on Reverse Side)

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.

I X19511

RECEIVED
District Health Officer No. 10
District File Number 9-41-1625
Date Filed SEP - 8 1941

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 Grace Pauline Lind

Licensed Embalmer No. 2204

P. O. Address Bowling Green

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

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

No. 2B
—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29107

Registration District No. 689 Primary Registration District No. 3033 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ada Overton
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 27 (Day) 1903 (Year)

8. AGE: Years 38 Months 6 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 3 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death No delivery	
Due to No delivery	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. B. Wilcoxon (M. D. or other)
Address T. K. Wilcoxon Date signed
Bowling Green Mo

SUPPLEMENTARY