

FILLED NOV 17 1941

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

35098
Do not use this space.

1. PLACE OF DEATH *043*
(a) County *Hickory* Registration District No. *1055*
(b) Township *Jordan* Primary Registration District No. *6271*
(c) City *Jordan - Mo* (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 *Emma Alice Overley*
(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 *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 *John Overley*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 11, 1860*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 6 5

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.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. 0*

FATHER
13. NAME *John Lewis*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. 0*

MOTHER
15. MAIDEN NAME *Charlotte Perkin*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo. 0*

17. INFORMANT (ADDRESS) *John Overley Jordan - Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Union Cem* DATE *9/17 39*

19. FUNERAL DIRECTOR (ADDRESS) *J R Luckey Wheatland Mo*

20. FILED *Sept 20 1938* *Homer Phillips* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 16 1939*

22. I HEREBY CERTIFY, That I attended deceased from *July 2*, 19*36*, to *Dec*, 19*38*
I last saw him alive on *Aug 20*, 19*38* Death is said to have occurred on the date stated above, at *2:00 a* m.
The principal cause of death and related causes of importance were as follows:
Chronic congestion liver causing dropsical foundation Date of onset _____

Other contributory causes of importance: *1318*
Nephritis (Bright's disease)

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) *J R Luckey* _____, M. D.
(Address) *Wheatland Mo.*

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.

DEPARTMENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 11-41-1874

Date Filed 11-13-44

STATEMENT BY LICENSED EMBALMER

I, JR Luckey, Licensed Embalmer No. 2982

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed JR Luckey

Licensed Embalmer No. 2982

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

35098

Registration District No. 1055

Primary Registration District No. 6271

Registrar's No. _____

1. PLACE OF DEATH

(a) County Hickory
(b) City or town Jordan
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory
(c) City or town Jordan Rural
(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 Emma A. Crusley
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
to _____ 19____
that I last saw him _____ days on _____ 19____
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife William B. Crusley 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar. 11 - 1881
(Month) (Day) (Year)

Immediate cause of death _____

8. AGE: Years 79 Months 6 Days _____ If less than one day _____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business _____

Major findings: Of operations _____

Of autopsy _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 20, 1939 (b) Mary F. Charlstrom
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

