

S. No. 2
DM-5-42
Rev. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30940**

FILED OCT 19 1944
Registration District No. **2000**

Primary Registration District No. **2000**

Registrar's No. **784**

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mary E. Wilson Home - 924 N. Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield,**
(If outside city or town limits, write "RURAL")
(d) Street No. **Mary E. Wilson Home - 924 N. Main**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **No**

3. (a) PRINT FULL NAME **Frances Overturf**
(b) If veteran, name war **None**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** day **26th**
year **1944** hour **2:10** minute **A.** M.

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
(b) Name of husband or wife **Frank Overturf**
6. (c) Age of husband or wife if alive **Dec. 1854**
7. Birth date of deceased **August 1, 1854**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 24 1944** to **Sept 25 1944**
that I last saw him alive on **Sept 25 1944**
and that death occurred on the date and hour stated above.

8. AGE: Years **90** Months **1** Days **25**
If less than one day hr. min.

Immediate cause of death **Perforated Hemorrhage**
Due to **ARTERIA PULMONIS**
Duration **4 days**

9. Birthplace **Unknown Iowa**
(City, town, or county) (State or foreign country)

Due to **ARTERIA PULMONIS**
Other conditions (Include pregnancy within 3 months of death)
Major findings: **g30**
Of operations **✓**
Of autopsy **✓**

10. Usual occupation **In Home**
11. Industry or business
12. Name **August Hammer**
13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

PHYSICIAN **g30**
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. A. S. E. Sanders**
(b) Address **Springfield, Missouri**

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?

17. (a) **Burial** (b) Date thereof **Sept. 28, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Maple Park Cemetery**
18. (a) Signature of funeral director **Alma Lohmeyer Funeral Home**
Springfield, Missouri
(b) Address
19. (a) **9-27-44** (b) **B. W. Handley**
(Date received local registrar) (Registrar's signature)

23. Signature **AM. Hoover** (M. D. or other)
Address **324 1/2 W. 5th St. Springfield, Mo.** Date signed **9/27/44**

(Licensed Embalmer's Statement on Reverse Side)

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

29
26

984

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.