S. No. 2
M—2-43
. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 21 1945

State File No. 29302

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 8088

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Little Sisters of the Poor. 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4221 Russell Avenue. 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary A. Overstreet

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William Overstreet.

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased March 25, 1867.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	5	21	hr. min.

9. Birthplace Toronto, Canada. 7
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business

FATHER 12. Name Michael D. Woods.

13. Birthplace Ireland. 7
(City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Emily Mitchel.

15. Birthplace England. 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Cecelia Woods.

(b) Address 6002 Maple Avenue.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-1945. (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) SEP 17 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15 year 1945 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from September 1, 1945, to September 15, 1945 that I last saw her alive on September 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis ??? (Duration)

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

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) None

(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) Manner of injury

23. Signature Bernard K. Stoke (M. D. or other)

Address 2502 Salisbury St. Date signed 9-15-45

(Licensed Embalmer's Statement on Reverse Side)

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 Clement M Neary.

Licensed Embalmer No. 3732

P. O. Address St Louis Mo.

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.