

No. 2
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X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32021**

Registration District No. **272**

Primary Registration District No. **5912**

Registrar's No. **111**

1. PLACE OF DEATH:
 (a) County **Demarquette**
 (b) City or town **Route to St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Blytheville Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
 In this community **4** years, months or days

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

3. (a) PRINT FULL NAME **Mary Francis Oversturf**
 3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **28**
 year **1947** hour **6** minute **P** M.
 21. I hereby certify that I attended the deceased from **7-24-47**
 _____, 19____ to **7-28-47**, 19____
 that I last saw her alive on **7-28**, 19____
 and that death occurred on the date and hour stated above.

4. Sex **F** / 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: **Sept 10 1936**
 (Month) (Day) (Year)
 8. AGE: Years **10** Months **10** Days **9** If less than one day hr. _____ min. _____

Immediate cause of death: **Respiratory Paralysis**
Polio Myelitis
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

MOTHER FATHER
 9. Birthplace **Denton Mo**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Student**
 11. Industry or business _____
 12. Name **EE Oversturf**
 13. Birthplace **Rushitt Ark**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Michelle Muehler**
 15. Birthplace **Steele Mo**
 (City, town, or county) (State or foreign country)
 16. (a) Informant **EE Oversturf**
 (b) Address **Steele Mo**
 17. (a) **Burial** (b) Date thereof **7-29-47**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Steele Mo**
 18. (a) Signature of funeral director **J. D. Gorman**
 (b) Address **Steele Mo**
 19. (a) **9-1-47** (b) **L. E. Edmiston**
 (Date received local registrar) (Registrar's signature)

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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature **L. E. Edmiston** (M: D. or other) _____
 Address **Blytheville, Ark.** Date signed **8/21/47**

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

9-47-252

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..... *John G. German*

Licensed Embalmer No. *4355*

P. O. Address..... *Bayter McBox 4*

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.

Registration District No. *272*

Primary Registration District No. *0912*

1. PLACE OF DEATH:

(a) County *Ray*
(b) City or town *State Rural Virginia*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
and in ambulance
(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)

3. (a) PRINT FULL NAME *Mary Francis Overton*

3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *S*

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive *same*

7. Birth date of deceased *Sept 10 1923*
(Month) (Day) (Year)

8. AGE: Years *10* Months *1* Days *10* If less than one day.....
hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name *E.E. Overton*

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

14. Maiden name *Mable Meeker*

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

16. (a) Informant *E.E. Overton*

(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof *7-29-47*
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *2-2-47* (Date received local registrar) (b) *L.T. Reiman* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Pemiscot*
(c) City or town *Verdon*
(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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day *28* Year *1947* Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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?..... (c) Means of injury.....

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

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-32021.