

FILED MAY 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17577**
Registrar's No. **3995**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY 5800 Arsenal St.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary		d. STREET ADDRESS (If rural, give location) 6332 JUNIATA	

3. NAME OF DECEASED (Type or Print) a. (First) Anna	b. (Middle) Nettie	c. (Last) Overton	4. DATE OF DEATH (Month) (Day) (Year) May 2 1949
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 9/13/1867	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 5 Days 29	IF OVER 1 YEAR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Smith	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE William T. Overton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Miss Rose Ammerman ADDRESS 6332 Juniata
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia		4 years	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 93rd
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 48/2 X
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22. I hereby certify that I attended the deceased from **July 7, 1948**, to **May 2, 1949** that I last saw the deceased alive on **May 2, 1949**, and that death occurred at **9:00 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clotus L. Krag M.D.	23b. ADDRESS 5600 Arsenal St St Louis	23c. DATE SIGNED May 3, 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/4/1949	24c. NAME OF CEMETERY OR CREMATORY Dickson Cemetery	24d. LOCATION (City, town, or county) (State) Dickson, Tenn
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DATE REC'D BY LOCAL REG. MAY 4 1949	REGISTRAR'S SIGNATURE J. B. Lanster	FUNERAL DIRECTOR'S SIGNATURE Bell Campbell Maternity ADDRESS 4215 Dundell
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

3

MAY 20 1949

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.....

Student Embalmer No.

working under my personal supervision.

Signed.....

Ray E. Campbell

Signed.....

Student Embalmer

Licensed Embalmer No.

3881

P. O. Address.....

H. Lewis, 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.