

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014275

STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 254 Primary Registration District No. 4386 Registrar's No. 10

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

68  
17

1. PLACE OF DEATH a. COUNTY <u>Oregon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Oregon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Thayer</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Thayer</u> 0750 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/> Length of stay in 1b/ <u>104ks</u>		d. STREET ADDRESS <input checked="" type="checkbox"/> (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clairdella Overstreet</u>			4. DATE OF DEATH Month Day Year <u>4-21-1959</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1872</u>
9a. AGE (In years (at birthday) <u>86</u> Months <u>7</u> Days <u>22</u>		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Winkney Rague</u>	
14. MOTHER'S MAIDEN NAME <input checked="" type="checkbox"/>		15. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	18. INFORMANT <u>C. Overstreet, Thayer, Mo.</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>4222</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>1-1-59</u> to <u>4-21-59</u> and last saw her <sup>her</sup> alive on <u>4-20-59</u> Death occurred at <u>7:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John R. Eason M.D.</u> (Degree or title)		22b. ADDRESS <u>Thayer Mo</u>	22c. DATE SIGNED <u>4-22-59</u>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <u>4-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Thayer Mo</u>
24. FUNERAL DIRECTOR <u>Robertson's Mortuary Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-22-59</u>	26. REGISTRAR'S SIGNATURE <u>Arthur Wolff</u>

**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.

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 2437 .....

P. O. Address Blount, Ala .....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

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