

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016486

STATE FILE NUMBER

FILED MAY 4 1959

Registration District No. 381

Primary Registration District No. 6183

Registrar's No. 35

300
-57

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1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY Don't know	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Milan		c. CITY OR TOWN Denver	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Frazier Nursing Home		d. STREET ADDRESS (If outside, give location) Don't know	
3. NAME OF DECEASED (Type or print) First John Middle Dennis Last Overstreet		4. DATE OF DEATH Month April Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) Grundy County, Mo
13a. FATHER'S NAME James Newton Overstreet		13b. MOTHER'S MAIDEN NAME Sarah Dennis	14. NAME OF HUSBAND OR WIFE Divorced
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. 325-09-9891	17. INFORMANT Address Mrs. Goldia Bartlett, Green City, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Tongue			INTERVAL BETWEEN ONSET AND DEATH 4:00
DUE TO (b) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1419			
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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input 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 GREEN CITY SULLIVAN MO	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph E. Hartman		22b. _____	
22c. DATE SIGNED 4/28/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 28, 1959	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or country) (State) Green City, Mo.	
24. FUNERAL DIRECTOR Glenn E. Hartman, Green City, Mo.		25. DATE RECD. BY LOCAL REG. 4-30-59	
		26. REGISTRAR'S SIGNATURE Mrs. M. W. Beckett	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Karl R. Kent*

Licensed Embalmer No. *4689*
P. O. Address *Green City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.