

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020151  
STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 381 Primary Registration District No. 4514 Registrar's No. 51

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Sullivan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Green City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Green City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Own Home</b>		Length of stay in lb <b>80 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>No street address</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Della</b> Last <b>Overstreet</b>			4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1871</b>	9. AGE (In years less birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Green City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Francis Marion Overstreet</b>		13b. MOTHER'S MAIDEN NAME <b>Don' know</b>		14. NAME OF HUSBAND OR WIFE <b>Never married</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Alberta Pfeiffer, Green City, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 MIN.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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			
21. I attended the deceased from <b>JUNE 6, 1959</b> to <b>JUNE 6, 1959</b> and last saw her alive on <b>JUNE 6, 1959</b> Death occurred at <b>7:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. E. Pfeiffer M.D.</b>			22b. ADDRESS <b>Green City Mo</b>		22c. DATE SIGNED <b>June 9, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green City Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Green City, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Glenn E. Kenton, Green City, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>6-11-59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. M.W. Beckett</b>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.