

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024143

FILED VS AUG 4 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 334

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>	Length of stay in 1b <b>12 days</b>	c. CITY OR TOWN <b>Booneville</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>Medical Center,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>811 E. High St.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Leonard</b> Last <b>Overshiner</b>			4. DATE OF DEATH Month <b>7</b> Day <b>27</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-3-13</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi-Cab driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Booneville, Cooper, Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Rafe Overshiner</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Meier</b>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>496-01-3424</b>		17. INFORMANT Address <b>Hospital Records,</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>LAENNEC'S CIRRHOSIS</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 a.m. p.m.	Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <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>7/15/59</b> to <b>7/27/59</b> and last saw him alive on <b>7/27/59</b> Death occurred at <b>1055 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>J. Sanders M.D.</b> (Degree or title)	22b. ADDRESS <b>Univ of Mo. Med Center</b>	22c. DATE SIGNED <b>7/27/59</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>July 29 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove</b>	23d. LOCATION (City, town, or county) <b>Booneville Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Lyman Sprinkle, Columbia, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>July 27 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

or by \_\_\_\_\_, \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4425

P. O. Address Columb

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.