

**R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028534**

**FILED VS AUG 17 1959**

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 113 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>COOPER</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOONVILLE</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>BOONVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPH HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>WASHINGTON ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BETTIE</u> Middle <u>-</u> Last <u>OVERTON</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>12</u> Year <u>59</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</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>MAY 1 1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>BOONVILLE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>MARIE FRAISER</u>			14. NAME OF HUSBAND OR WIFE <u>? BOONVILLE MO</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give <u>  </u> or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>EUPENIA COLEMAN 714-774 ST</u>			
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>Arterio sclerotic heart disease</u> DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>								
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 <u>Aug 10-59</u> and last saw her alive on <u>Aug 12-59</u> Death occurred at <u>12:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>M. DeLoach M.D.</u> (Degree or title)				22b. ADDRESS <u>Boonville Mo</u>			22c. DATE SIGNED <u>8/14/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG 15 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CLARKFORK</u>		23d. LOCATION (City, town, or county) <u>COOPER</u>		STATE <u>MO</u>		
24. FUNERAL DIRECTOR <u>H. MAY</u> ADDRESS <u>814 S. PORTER</u>			25. DATE RECD. BY LOCAL REG. <u>8/15/59</u>		26. REGISTRAR'S SIGNATURE <u>D. Hooper</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 8 T 9171

**STATEMENT BY LICENSED EMBALMER**

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

working under my personal supervision.

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

Signed George Trammell

Licensed Embalmer No. 4425

P. O. Address Columbia

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.