

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 11 1959

59-040788

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 100

RECEIVED

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Lexington		Length of stay in 1b 16 hr.	c. CITY OR TOWN Kansas City, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2619 East 29th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Lisa Rane Overstreet			4. DATE OF DEATH Month November Day 27 Year 1959		
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5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. November 26-1959	9. AGE (last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 16 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Lexington, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Henry C. Overstreet	13b. MOTHER'S MAIDEN NAME Anita Darlene Coen	14. NAME OF HUSBAND OR WIFE none
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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. none	17. INFORMANT Henry C. Overstreet Address 2619 E 29th Street Kansas City, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (Born 24 hr w/pt programming) DUE TO (b) Premature Labor DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 16 hrs.
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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 checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 Higginsville, Missouri	COUNTY _____ STATE _____
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21. I attended the deceased from 11-26-59 to 11-27-59 and last saw her alive on 11-27-59
 Death occurred at 2:14 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wilbur E. Fulcherson M.D.	22b. ADDRESS Higginsville Mo	22c. DATE SIGNED 12-2-59
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-28-1959	23c. NAME OF CEMETERY OR CREMATORY City	23d. LOCATION (City, town, or county) (State) Higginsville, Missouri
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24. FUNERAL DIRECTOR Forrest A. Hoefler	ADDRESS Higginsville, Mo.	25. DATE RECD. BY LOCAL REG. 12-4-59	26. REGISTRAR'S SIGNATURE Wm E Eastbrook
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Forest R. Hoefler

Licensed Embalmer No. 480I

P. O. Address Higginsville, 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.