

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 20 1960

146

Registration District No. _____ Primary Registration District No. _____

3026

Registrar's No. _____

36

=60-002043

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jackson				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) Independence		Length of stay in 1b 18 Months		c. CITY OR TOWN Oak Grove		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 3715 Hardy St. Four Pines Retirement Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R. #2	
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Overton				4. DATE OF DEATH Month Jan. Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-30-76	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME JOHN W. INGALLS			13b. MOTHER'S MAIDEN NAME ORILLA STEPHENSON			14. NAME OF HUSBAND OR WIFE ALBERT OVERTON	
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. NO		17. INFORMANT JAMES R. LEIGHTOR 6019 EAST 11 TH ST Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock due to Recurrent Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of Corpus Uteri 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						INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 Aug 1958 to Jan 7, 1960 and last saw her alive on Jan 4, 1960 . Death occurred at 11:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Dr. E. Schuman M.D. (Degree or title)				22b. ADDRESS 9306 E New 40 Hwy Independence, Mo.		22c. DATE SIGNED 1/9/60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN 11, 1960	23c. NAME OF CEMETERY OR CREMATORY WOOD LAWN CEM			23d. LOCATION (City, town, or county) (State) INDEP. MO.	
24. FUNERAL DIRECTOR D.W. Newcomers Sons Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 1-11-60		26. REGISTRAR'S SIGNATURE James H. Craig	

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas W. Larson

Licensed Embalmer No. 4889

P.O. Address N.C., No.

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.