

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Henry Registration District No. 14 File No.
Township Primary Registration District No. 1211 Registered No. 2
City Windsor (No.) St. Ward)

2. FULL NAME

Mrs. Sarah Overshine
(a) Residence, No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Geo. Overshine

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29-1841

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 | 6 | 8 |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Cedar Co., Mo.

10. NAME OF FATHER

Abraham Howard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT Mrs. Carrie Overstreet
(Address) Windsor, Mo.

15.

FILED W. E. Huston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1925, to Jan 7, 1926 that I last saw her alive on Jan 7, 1926, and that death occurred, on the date stated above, at 10-30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

115 Influenza

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. A. Blackmore, M. D.

1-10, 1926 (Address) Windsor, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Windsor Mo Jan 9 1926

UNDERTAKER W. E. Huston ADDRESS Windsor Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF.....

6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)
 10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY, OR TOWN)..... (STATE OR COUNTRY)
 14. INFORMANT (Address)..... REGISTRAR.....

15. FILED..... 19..... REGISTERED.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....
 17. I HEREBY CERTIFY, That I attended deceased from..... 19.....
 that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. da.
 18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. da.
 IF NOT AT PLACE OF DEATH..... DATE OF.....
 DID AN OPERATION PRECEDE DEATH.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19..... (Address).....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....
 20. UNDERTAKER..... ADDRESS.....