

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH		Registration District No. <u>104</u>	File No. <u>9002</u>
County <u>Callaway</u>		Primary Registration District No. <u>2008</u>	Registered No. <u>70</u>
Township		(No.) St.	Ward
City <u>Fulton</u>			
2. FULL NAME <u>Viola Overstreet</u>			
(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.
		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)	
<u>F</u>	<u>W</u>	<u>S</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (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)			
15. <u>3-19-31 R. N. Crews</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>Mar 17 19 31</u>			
17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19....., and that I last saw him since on 19....., and that death occurred, on the date stated above, at..... m.			
THE CAUSE OF DEATH* WAS AS FOLLOWS:			
..... (duration) yrs. mos. da.			
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.			
18. WHERE WAS DISEASE CONTRACTED			
IF NOT AT PLACE OF DEATH.....			
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....			
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.			
19. PLACE OF BURIAL, CREMATION, OR REMOVAL			DATE OF BURIAL
			19
20. UNDERTAKER			ADDRESS

S-9002