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.

REC'D MAR 8 1939

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

6452
Do not use this space.

1. PLACE OF DEATH
(a) County Franklin 1 Registration District No. 297
(b) Township Primary Registration District No. 3016 Registered No. 19
(c) City Washington 1 (d) Street No. St. Francis Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 16 ds. (f) How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

2. PRINT FULL NAME 162 FRANK GREEN, OVERSTREET
(a) Residence, No. Pacific, Mo St. Pacific Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male ~~white~~
4. COLOR OR RACE white
5. ~~SINGLE~~, MARRIED, ~~WIDOWED, OR DIVORCED~~ (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MYRTLE DODSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-22-1893

7. AGE YEARS 45 MONTHS 6 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Steel worker
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Franklin Mo

FATHER
13. NAME John Overstreet
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Franklin Mo

MOTHER
15. MAIDEN NAME Olive King
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT (ADDRESS) Mrs. Modena Carlson New Franklin, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE New Franklin Mo DATE 2-19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. S. Duncan New Franklin Mo.

20. FILED Feb. 16 1939 H. A. May Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 16 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1939, to Feb 16, 1939
I last saw him alive on Feb 15, 1939. Death is said to have occurred on the date stated above, at 4:00 a.m.
The principal cause of death and related causes of importance were as follows:

Infected scalp wound, followed by 1 Osteomyelitis of left occipital area of skull 2 Septicemia 3 Meningitis 4 Pyogenic metastasis to right hip

Date of onset about Jan 15, 1939

Other contributory causes of importance:

194 B

Name of operation none Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury Unknown 19..
Where did injury occur? Clarksville, Mo (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. In industry
Manner of injury Jumped head on bridge beam
Nature of injury scalp wound

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Frank G. Mays, M. D.
(Address) 311 W 4th, Washington, Mo

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(Licensed Embalmer's Statement on Reverse Side)

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed N. L. Hall

Licensed Embalmer No. 3515

P. O. Address New Franklin, T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.