

No. 2
1-10-39
17-30
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

APR 1 1943
Registration District No. 340

Primary Registration District No. 6152

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bernie (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 10.3

(c) City or town Bernie, (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Ira Maud Overman

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1943 hour 10 minute 20 P. M.

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Vester O. Overman

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased October 2 1898
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 9
1942, to March 15, 1943
that I last saw her alive on March 15, 1942
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

44	5	15	hr. _____ min.
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Immediate cause of death Of fracture

Duration 2 weeks

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)

Due to Hernia

Due to _____

10. Usual occupation House-Wife

Other conditions (Include pregnancy within 3 months of death)

Major findings: Tuberculosis ✓

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name Sanford Smith

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Cora Mann
(City, town, or county) (State or foreign country)

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Vester O. Overman

(b) Address Bernie, Mo. R. F. D. #1

17. (a) Burial (b) Date thereof 3-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Blankenship-Strickland
(b) Address Bernie, Missouri

19. (a) 3-28-43 (b) Cardie Miller
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature F. O. Kelley D.O. (M. D. or other) _____
Address Bernie, Mo. Date signed 3-18-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 442-470

Date Filed 4-12-48

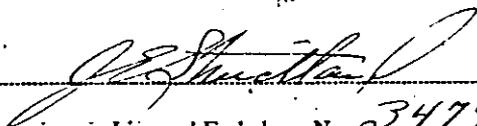
STATEMENT BY LICENSED EMBALMER

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


.....
Licensed Embalmer No. 3479

P. O. Address Wesley, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11666
Registrar's No. 18

Registration District No. 340

Primary Registration District No. 6152

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ira Maud Overman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 2 1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days _____
If less than one day in min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him/her alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death obstruction

Due to bernia

Due to _____

Other conditions nephritis chronic
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ Means of injury _____

23. Signature F O Valley D O (M.D. or other) _____
Address Box 157 Bernie Mo Date signed 5/3/43

SUPPLEMENTARY

S-11666

MAR 16 1944