

FILED SEP 20 1948

Registration District No. 255

Primary Registration District No. 5875

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon
 (b) City or town Thomsonville, Mo
 (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 5 1/2 hrs (Specify whether
 In this community 5 1/2 hrs
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Oregon
 (c) City or town Thomsonville, Mo
 (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 7 day 17
 year 1948 hour 4 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from 25 June 48 to 17 July 48
 that I last saw him alive on 12 July 48 and that death occurred on the date and hour stated above. Duration

Immediate cause of death:
Carcinoma of Liver
with generalized
metastases to
abdominal viscera

Due to _____
 Due to _____
 Other conditions:
 (Include pregnancy within 3 months of death)

Major findings: Confirmed diagnosis
 Of operations _____
 Of autopsy H&E

PHYSICIAN

Underline the cause of 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? _____ (Specify type of place)

While a _____ (Specify type of place)
 23. Signature Robert L. Smith, M.D. (M. D. or other)
 Address West Plains, Mo Date signed 23/7/48

3. (a) PRINT FULL NAME Gas Fletcher Overstreet

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 498-28-8267

4. Sex mo 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Helen Willard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 10/22-1896
 (Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days 25 If less than one day (hr. min)

9. Birthplace Oregon Co., Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Mrs. Overstreet

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

14. Maiden name Audrey Hogg

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

16. (a) Informant Mrs. Julene White

(b) Address Thomsonville, Mo

17. (a) 18 (b) Date thereof 7-19-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Hill

18. (a) Signature of funeral director Robert L. Smith

(b) Address West Plains, Mo

19. (a) 10-7-48 (b) Mrs. N. C. Johnson
 (Date received local registrar) (Registrar's signature)

~~Date Filed~~
District File Number 9-13-48
District Officer No. 5
RECEIVED 9-13-48

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

H. J. Roberts

Licensed Embalmer No. 3437

P. O. Address West Plains, 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, fact should be so stated above.

2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct

FILED OCT 11 1948

Registration District No. 255

Primary Registration District No. 5875

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Thomasmulle
(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 Jas. J. Overstreet

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Oct 22
(Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) 10-2-48 (b) Mrs W C Bohneal's
(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 1948 year _____ hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

Other conditions _____ (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? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

RECEIVED 10-7-48
District Health Officer
District File Number 948570
Photo Filed 10-7-48

1948
S-30534