

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **694**

FILED JAN 22 1958

Registration District No. **82** Primary Registration District No. **3017** Registrar's No. **9**

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY COOPER	
b. CITY - (If outside corporate limits, give TOWNSHIP only) OR TOWN BOONVILLE		c. CITY OR TOWN BOONVILLE	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at Home		d. STREET ADDRESS (If outside, give location) 812 1/2 REAR WATER	

3. NAME OF DECEASED (Type or print) EDMOND - OVERTON			4. DATE OF DEATH Month JAN Day 13 Year 58		
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 16-1876	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS.: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) COOPER CO. MO	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE LAURA - OVERTON
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT LAURA OVERTON Address 812 1/2 WATER ST
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Residual ulcer		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 2/15/57 to 1/13/58 and last saw ^{her} him alive on 1/11/58 Death occurred at 3:45 pm on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Digitally or in ink) William A. Clark M.D.	22b. ADDRESS 329 main, Boonville, Mo	22c. DATE SIGNED 1-15-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN-17-58	23c. NAME OF CEMETERY OR CREMATORY CHARLES FORT	23d. LOCATION (City, town, or county) (State) COOPER MO
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24. FUNERAL DIRECTOR Halwell J. May ADDRESS 814 S. PORTER	25. DATE RECD. BY LOCAL REG. 1-16-58	26. REGISTRAR'S SIGNATURE W. Hooper
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *George H. Green*

Licensed Embalmer No. *4220*

P. O. Address *Metairie*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.