

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
 FILED VS MAY 16 1960

**-60-019209**

Registration District No. 140 Primary Registration District No. 4229 Registrar's No. 52 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>New Franklin</b>		Length of stay in 1b <b>68 yrs.</b>	c. CITY OR TOWN <b>New Franklin</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>203 N. Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>203 N. Missouri</b> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Forbis</b> Last <b>Dwyer</b>	4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1891</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John H. Overstreet</b>	13b. MOTHER'S MAIDEN NAME <b>Ollie King</b>	14. NAME OF HUSBAND OR WIFE <b>Albert Dwyer</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>489-16-1847</b>	17. INFORMANT Address <b>Mrs. Edwin Dodson New Franklin</b>
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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) <b>Cerebral vasospasm due to hypertensive arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 11-15-59 to 4-26-60 and last saw her/him alive on 4-26-60  
 Death occurred at 3:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>William A. Welch M.D.</i> (Degree or title)	22b. ADDRESS <b>329 Main St., Boonville, Mo.</b>	22c. DATE SIGNED <b>5-12-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 13, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>New Franklin Mo.</b>
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24. FUNERAL DIRECTOR <b>Markland Hall New Franklin, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-13-60</b>	26. REGISTRAR'S SIGNATURE <i>Katherine Welch</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

any evidence of any other person's signature on the reverse side of this certificate

STATEMENT BY LICENSED EMBALMER

MAY 19 1960

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 Tom D. Markland

00-25-4

00-25-4

00-21-11

Licensed Embalmer No. 4592

MAY 19 1960

P. O. Address New Franklin

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.

00-21-2