PLACE OF DEATH

County Shannon

Township Monteer

or Village

or City (No. St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 4959

Registration District No. 825 File No. 27

Primary Registration District No 6085 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Amelia Margaret Overcast

PERSONAL AND STATISTICAL PARTICULARS

SEX: F.

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: June (Month) 14 (Day), 1896 (Year)

AGE: 23 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer): Household duties

BIRTHPLACE (City or town, State or foreign country): Big Rat, Mich.

PARENTS

NAME OF FATHER: Henry Segman

BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown

MAIDEN NAME OF MOTHER: Hattie Hansen

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Overcast

(ADDRESS) Monteer Mo

Filed 11-28 1919 O. Butcher. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: November (Month) 27 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from No Physician in attendence Information furnished by Husband, that I last saw h[illegible] alive on [illegible] and that death occurred, to the best of my knowledge, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and heart trouble.

23A
95B

(Duration) 4 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Orrv Butcher L.R.

11-28 1919 (Address) Monteer, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Birch Tree Cemetery

DATE OF BURIAL: 11-29 1919

UNDERTAKER: M. P. Smotherman

ADDRESS: Fereita, Mo.

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

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER
(City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(SECONDARY)

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS