WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

34388

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 9745

City ST. LOUIS MO. (No. En route City Hospital #1 St. ..... Ward)

2. FULL NAME WILLIAM JOHN OVERBECK.

(a) Residence. No. 4483 LEE AVE. St., 10 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE.
4. COLOR OR RACE: WHITE.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): MARRIED.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: LENA OVERBECK.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 4/13/1870

7. AGE: YEARS 60 | MONTHS 5 | DAYS 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: MEAT CUTTER.
(b) General nature of industry, business, or establishment in which employed (or employer): RETIRED.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): GERMANY OVERBECK.

PARENTS
10. NAME OF FATHER: WM. JOHN OVERBECK.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): GERMANY.
12. MAIDEN NAME OF MOTHER: NOT KNOWN.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): GERMANY.

14. INFORMANT: Mrs Lena Overbeck.
(Address) 4483 Lee Ave

15. FILED OCT 13 1930 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 12 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11-45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 9/13

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Hurley, M.D.

10/13, 1930 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: ST. PETERS CEMETERY.
DATE OF BURIAL: 10/14/30

20. UNDERTAKER: Provost Lund Co
ADDRESS: 3710 N Grand