

Registration District No. 297Primary-Registration District No. 3016Registrar's No. 97

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town Washington
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 14 days (Specify whether
 years, months or days)
 In this community 14 days

8. (a) PRINT FULL NAME Raymond August Overeschmidt8. (b) If veteran,
name war 8. (c) Social Security
No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married,
divorced Single
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if
 alive None years
 7. Birth date of deceased October 6, 1940
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>14</u>	hr. min.

9. Birthplace Washington, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation None11. Industry or business NONE12. Name Raymond William Overeschmidt13. Birthplace Union, Missouri
(City, town, or county) (State or foreign country)14. Maiden name Agnes Francis Henschel15. Birthplace Rollaville, Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Raymond Overeschmidt(b) Address Union, Mo. R.F.D.#217. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1940
(Month) (Day) (Year)(c) Place: burial or cremation Moselle, Missouri18. (a) Signature of funeral director Hieburg & Witt Inc., F.H. Witt(b) Address Washington, Missouri19. (a) Oct. 20, 1940 (Date received local registrar) (b) H. A. May (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
 (c) City or town Union Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Union, Mo. R.F.D.#2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October, day 20
year 1940 hour 4 20 minute 9 P. M.21. I hereby certify that I attended the deceased from October 6th,
1940, to October 20, 1940,
that I last saw him alive on October 20, 1940,
and that death occurred on the date and hour stated above.Immediate cause of death Hemorrhage and ShockDue to Subar - Enterostomy OperationDue to Atresia of Duodenum (Congenital & Complete)Other conditions None
(Include pregnancy within 3 months of death)Major findings: Six inches of Duodenum below Renal Caps had no lumenOf autopsy None performed22. 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?
270 (Specify type of place) _____
While at work? _____ (e) Means of injury _____23. Signature Charles E. Sutton B.S.M.D. (M. D. or other)Address 13 Elm St Washington Date signed 10/20/40

Duration

One Day4 daysBirth

PHYSICIAN

Underline the cause to which death should be charged statistically

NOV 17 1940

NOV 15 1940

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.