

No. 2  
-2-43  
-17-39  
X35597

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42553 ✓

FILED DEC 17 1943

State File No. \_\_\_\_\_

Registration District No. 146

Primary Registration District No. 5568

Registrar's No. 298

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Blue Township  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
10530 E. 6th St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 20 year  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 10530 E 6th St  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fred Overman

3. (b) If veteran, name war →

3. (c) Social Security No. 500-22-8781

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced /

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased: June 6 - 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>5</u>	<u>8</u>	hr. min.

9. Birthplace Sibley Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Machine Operator

11. Industry or business Lake City Ordnance Plant

12. Name George Overman

13. Birthplace West Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Shram

15. Birthplace Independence Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Irene Overman

(b) Address 10530 E 6th St

17. (a) Burial (b) Date thereof: Nov 16 - 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Mo

18. (e) Signature of funeral director Att & Mitchell

(b) Address 310 N. Main St Ind Mo

19. (a) 11-16-1943 (b) James Overman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14  
year 43 hour 12:30 PM M.

21. I hereby certify that I attended the deceased from 19  
19  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 178 C  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Section

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 11/14/43

(c) Where did injury occur: 10530 E 6th St  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place) (e) Means of injury Gasoline

23. Signature: J. E. [unclear] (D. or other) \_\_\_\_\_  
Address: [unclear] \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 17 1945

---

---

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Henry J. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep Mo

**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, fact should be so stated above.**

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Blue Jay  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Fred Overman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Irene Overman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 6 (Month) (Day) (Year)

8. AGE: Years 42 Months 5 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-31-1943 (Date received local registrar) (b) James W. Ross (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-42553