

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31231**

5-17-39
X37823

FILED 0050 4 1945

Registration District No. **225**

Primary Registration District No. **4421**

Registrar's No. **68**

1. PLACE OF DEATH:

(a) County **Platte**
(b) City or town **Parkville, Mo.**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME **James W. Overby**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Grace Ann Overby**
6. (c) Age of husband or wife if alive **?** years
7. Birth date of deceased **Nov. 14 1898**
(Month) (Day) (Year)

8. AGE: Years **46** Months **9** Days **17**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business **farmer**

MOTHER FATHER

12. Name **unknown**
13. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** ?
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Casbolt**
(b) Address **Parkville, Mo.**

17. (a) **burial** (b) Date thereof **Sept 3-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Second Creek, Ferrisburg, Mo.**

18. (a) Signature of funeral director **R. L. M. Stetell**
(b) Address **Platte City, Mo.**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Platte** 83
(c) City or town **Parkville, Missouri** 0
(If outside city or town limits, write RURAL)
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **1**
year **1945** hour **8** minute **25** A.M.
21. I hereby certify that I attended the deceased from **Oct 1944** to **Sept. 1 1945**
that I last saw him alive on **Sept 1 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Edema (pulmonary)**
Due to **Chronic Myocarditis**
Hypertension, arteriosclerosis
Due to **Rheumatic fever**

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **930**

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 **T. F. Casbolt** (M.D. or other) **MD**
Address **Parkville, Mo.** Date signed **Sept 1/1945**

1488

(Licensed Embalmer's Statement on Reverse Side)

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

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 Francis M. Giffie
Licensed Embalmer No. 4393
P. O. Address Platte City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. out
Registrar's No. 68

Registration District No. 280 Primary Registration District No. 4421

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Parkville
(If outside city or town limits, write "RURAL" and name of township)
(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

3. (a) PRINT FULL NAME James W. Overby
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 17 1941
(Month) (Day) (Year)

8. AGE: Years 46 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 1 - 46 (Date received local registrar) (b) Mrs. Alpha Rollins (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 Sept Day _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

31231