

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 1168

FILED NOV 10 1945
Registration District No. 42 Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community 7 days

3. (a) PRINT FULL NAME John P. Overlander

3. (b) If veteran, name war none

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 Lillian T. Overlander

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased January 24 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>9</u>	<u>5</u>	br. _____ min.

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

10. Usual occupation retired farmer

11. Industry or business _____

12. Name George W. Overlander

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

14. Maiden name Sarah Leener

15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John P. Overlander

(b) Address Highland, Kansas

17. (a) removal (b) Date thereof 10/30/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland, Kansas

18. (a) Signature of funeral director John Beale & Bowman

(b) Address 319 So. 10th

19. (a) Nov 2 1945 (b) J. H. Hattelbach
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Doniphan

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29
year 1945 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct/29 1945 to October 29, 1945
that I last saw h. im. alive on Oct. 29, 1945.

and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis, Chr.

Due to <u>Arteriosclerosis, general</u>	Duration <u>?</u>
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 J. H. Hattelbach (M. D. or other) _____
Address St. Joseph, Mo. Date signed 10/30

PHYSICIAN
Underline the cause to which death should be charged statistically.

Phy. & Surg. 1928

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 Gerald I. Wade

Licensed Embalmer No. 4172

P. O. Address St. Joseph

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.