

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36323
4780
Registrar's No.

FILED DEC 6 1945
Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
VINEYARD PARK HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 MINUTES
(Specify whether
In this community 40 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 5542 SOUTH BENTON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME MR. MURRAY LEE OVERAKER

3. (b) If veteran, name war NO 3. (c) Social Security No. 490-16-2573

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. KATHERINE OVERAKER
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased SEPTEMBER-18-1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>2</u>	<u>2</u>	hr. min.

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

10. Usual occupation MAINTENANCE DEPARTMENT

11. Industry or business BENSON MANUFACTURING CO.

12. Name SAMUEL MARTIN OVERAKER

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

14. Maiden name MARGARET REED

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

16. (a) Informant MRS. KATHERINE OVERAKER

(b) Address 5542 SOUTH BENTON

17. (a) BURIAL (b) Date thereof NOV-23-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILLS CEMETERY

18. (a) Signature of funeral director D. J. Newcomer

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 11-31-45 (b) Steadline Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 20TH
year 1945 hour 3 minute 50 P.M.

21. I hereby certify that I attended the deceased from 11-19
1945, to 11-20, 1945;
that I last saw him alive on NOVEMBER 20
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY THROMBOSIS Duration 3 Days

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 94a

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) To
(b) Date of occurrence To
(c) Where did injury occur? To
(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 5

23. Signature D. J. Newcomer (M. D. or other) MD

Address 925 Apple Blky N.C.K. Date signed 11/21/45

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

48
3
8

925 W. Myrtle Blvd.
11-5-36

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: *Paul Papp*

Licensed Embalmer No. *3458*

P. O. Address *K.C. 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.