

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12283

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

**FILED MAY 8 1946**

Primary Registration District No. 1000

Registrar's No. 496

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:  
419 Blake 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 1 week  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Linn 999  
(c) City or town Cedar Rapids 13  
(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) 21  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Richard Delbert Overman

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 Widower  
6. (b) Name of husband or wife Mary Frances Overman 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 16, 1868  
(Month) (Day) (Year)

8. AGE: Years 77 Months 9 Days 12 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired

11. Industry or business Farmer

12. Name John Overman

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

14. Maiden name Rachael West

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

16. (a) Informant Mrs. Wayne Wilson  
(b) Address 419 Blake St.

17. (a) Removal (b) Date thereof May 1, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland, Kansas

18. (a) Signature of funeral director [Signature]

(b) Address 5025 King Hill Ave.

19. (a) May 1, 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28  
year 1946 hour 5 minute 15 p M.

21. I hereby certify that I attended the deceased from Apr 20, 1946, to Apr 27, 1946,  
that I last saw h. im alive on Apr 27, 1946,  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Chronic asthma  
Major findings Enlargement of heart  
Of operations \_\_\_\_\_  
Of autopsy None

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) \_\_\_\_\_  
(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 [Signature] (M. D. or other) \_\_\_\_\_  
Address 670 Branch Date signed 5/29/46

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 4/28/46  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Emma Clark

Licensed Embalmer No. 4235

P. O. Address St Joseph 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.**