

S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
3-1946
STANDARD CERTIFICATE OF DEATH

27294

State File No.

Registrar's No. 3607

Registration District No. 149

Primary Registration District No. 1002

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

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 27 days
(Specify whether

In this community 13 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 911 E. 48 8
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME Alonzo Overbay

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19
year 1946 hour 1 minute A. M.

4. Sex Male 5. Color or race White

6. (a) Single, ¹widowed, married, divorced Married

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased: Dec. 18 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 23 1946 to August 19 1946
that I last saw him alive on August 19 1946
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>8</u>	<u>1</u>	hr. min.

Immediate cause of death Bronchopneumonia

Due to.....

Due to.....

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

10. Usual occupation Retired

11. Industry or business Missouri R.R.

12. Name Wm. Preston Overbay

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

14. Maiden name Susan Marshall

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

Other conditions 107
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy See above

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

16. (a) Informant Mrs. Dollie Harris

(b) Address 911 E. 48th St. K.C. Mo.

17. (a) Lawrence City, Neb. (b) Date thereof Aug 21 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence City, Neb.

18. (a) Signature of funeral director P. T. Fulton

(b) Address 1319 W. 18th St. K.C. Mo.

19. (a) 8-20-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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? Lawrence City, Neb.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? no (Specify type of place)
Means of injury no

23. Signature Wm. W. Ward (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 8-19-46

Dr. Buckner

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

P. C. Stulton

Licensed Embalmer No. 3503

P. O. Address F. C. Jensen

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.