

FILED APR 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10505

#74668

318

1003

State File No. 2898

BIRTH NO. 49-219008 REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		b. COUNTY Missouri	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hosnital #1.		d. STREET ADDRESS (If rural, give location) 3537 Page Ave.,	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) Infant GIRL			March 6th, 1949
b. (Middle)			
c. (Last) OVERTUFF			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH March 4th, 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 2 HRS. Hours Min.
			2
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Henry Overtuff		13b. MOTHER'S MAIDEN NAME Delores Fulghan	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME M.A. Renard
			St. Louis City Hospital

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15/49, 19, to 3/6/49, 19, that I last saw the deceased alive on 3/6/49, 19, and that death occurred at 9:05 AM, from the causes and on the date stated above.

23a. SIGNATURE S. Hughes	(Degree or title) M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 3/7/49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE MAR 31 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL MAR 31 1949	REGISTRAR'S SIGNATURE J. B. Sauter	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**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.