

No. 300
10-48

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25673

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2715

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Lawn		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 2 WKS		d. STREET ADDRESS (If rural, give location) 3709 N 11th St.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Shamrock Nursing Home			

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) H. c. (Last) Overy			4. DATE OF DEATH July 18th, 1951		
--	--	--	---	--	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb. 8th, 1871	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
----------------------	-------------------------------	---	--	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Florissant, Mo	12. CITIZEN OF WHAT COUNTRY? US
--	---	---	--

13a. FATHER'S NAME Frederick Guttar	13b. MOTHER'S MAIDEN NAME Rose Lamont	14. NAME OF HUSBAND OR WIFE Louis Overy
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Florence Borgmann	ADDRESS 826 Bittner St
--	-------------------------------	---	-------------------------------

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, asphyxia, etc. If 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) Chronic myocarditis		2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____		10 yrs?
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 checked="" 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 **1-9**, 19**50**, to **7-18**, 19**51**, that I last saw the deceased alive on **7-17**, 19**51**, and that death occurred at **1:25 Am.**, from the causes and on the date stated above.

23. SIGNATURE Eugene L. Arnold M.D. (Degree or title)	23b. ADDRESS 8700 Partridge	23c. DATE SIGNED 7/18/51
--	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 7/21/51	24c. NAME OF CEMETERY OR CREMATORY St. Ferdinand Cemetery	24d. LOCATION (City, town, or county) Florissant, Mo. (State) _____
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. 7-19-51	REGISTRAR'S SIGNATURE Hubert P. Tomber	25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home	ADDRESS 8319 Hallsferry
---	---	--	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4679

P. O. Address St. Charles, 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.