

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22468**
Registrar's No. **6004**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis, Mo. TOWN		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis TOWN 216	
		d. STREET ADDRESS (If rural, give location) 16 3218a Halliday	

3. NAME OF DECEASED (Type or Print) a. (First) William O. b. (Middle) c. (Last) Overall			4. DATE OF DEATH (Month) (Day) (Year) June 25, 1952		
--	--	--	---	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 29, 1884	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
--------------------	-------------------------------	---	--	---	---------------------------	-------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoemaker	10b. KIND OF BUSINESS OR INDUSTRY Blocker shoes	11. BIRTHPLACE (City and State or Foreign Country) Ky.	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	---

13a. FATHER'S NAME Wm. Overall	13b. MOTHER'S MAIDEN NAME Margaret Bivens	14. NAME OF HUSBAND OR WIFE Christine Overall
---------------------------------------	--	--

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. 497-05-476	17. INFORMANT'S SIGNATURE OR NAME Christine Overall	ADDRESS 3218a Halliday
--	---	--	-------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate.		DUE TO (b) General Metastases.		2 yrs.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		1 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia.				2 days

19a. DATE OF OPERATION Feb '52	19b. MAJOR FINDINGS OF OPERATION Transurethral resection.	20. AUTOPSY? YES <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 177X

22. I hereby certify that I attended the deceased from **Aug 1951**, to **June 25, 1952**, that I last saw the deceased alive on **June 25, 1952**, and that death occurred at **830p** m., from the causes and on the date stated above.

23a. SIGNATURE Paul Kimpsey Webb (Degree or title) MD	23b. ADDRESS 721 Olive St	23c. DATE SIGNED 6-26-52
---	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-27-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Paragould, Ark.
--	--------------------------	------------------------------------	--

DATE RECEIVED BY LOCAL REG. JUN 26 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd., St. Louis, Mo.
--	--	---	--

Paul
DR. WEBB
Chemical Body
Ch 693E

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.

Student
Student Embalmer

Signed John S. Plennel
Licensed Embalmer No. 9199
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.