

FILED JUN 5 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 19751  
5053

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis,</u>		c. LENGTH OF STAY (In this place) <u>11 Weeks</u>		c. CITY OR TOWN <u>Jennings, MO</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hospital.</u>				e. STREET ADDRESS (If rural, give location) <u>8725 Granada Pl.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u> b. (Middle) <u>F.</u> c. (Last) <u>Overmann.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 17 1953</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married.</u>	8. DATE OF BIRTH <u>July 21, 1904</u>		9. AGE (In years last birthday) <u>48</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>26</u>	IF UNDER 1 YEAR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Cutter.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Modern Jacket CO.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John H. Overmann.</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Flauaus.</u>		14. NAME OF HUSBAND OR WIFE <u>Estelle M. Overmann.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Estelle M. Overmann 8725 Granada Pl.</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left axillary sarcoma</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cause unknown</u>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Metastases to lungs &amp; spine</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Sarcoma involving muscles &amp; glands</u>				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? _____				1991		
22. I hereby certify that I attended the deceased from <u>Apr 18, 1948</u> , to <u>May 17, 1953</u> , that I last saw the deceased alive on <u>May 16, 1953</u> , and that death occurred at <u>3.30 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Reverend Karel M. O.</u>				23b. ADDRESS <u>1117 N Grand</u>		23c. DATE SIGNED <u>May 18, 1953</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 20, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, MO.</u>			
DATE REC'D BY LOCAL REG. <u>MAY 19 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Buchholz-Koeller 5967 W. Florissant Ave</u>				

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

Sarcoma in the axilla

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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..

Student.....  
Signature of Student Embalmer

Signed *William G. Embalmer*

Licensed Embalmer No. *211*

P. O. Address *A. P.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.