

FILED AUG 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25049

State File No.

318

1003

7013

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 MO b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS c. LENGTH OF STAY (In this place) Lifetime c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL e. STREET ADDRESS (If rural, give location) 226 3256 N. 20th Street 2269

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) c. (Last) OVERBECK 4. DATE OF DEATH (Month) (Day) (Year) JULY 28, 1954

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 8. DATE OF BIRTH Jan 21, 1873 9. AGE (In years last birthday) 81 If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.

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

13a. FATHER'S NAME John Overbeck 13b. MOTHER'S MAIDEN NAME Anna Bookrath 14. NAME OF HUSBAND OR WIFE Never Married

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. 489-03-1990 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Herman Loberg: 3248 N. 20th Street

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. It means the disease, injury, or complication which caused death. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) *infarction of sigmoid colon* ANTECEDENT CAUSES DUE TO (b) *Somewhat arteriosclerotic thrombosis* DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS *Overaged arteriosclerosis & senility. Chronic cystitis & urethritis & prostatitis* INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 5702

22. I hereby certify that I attended the deceased from 7-14-54, 19___, to 7-28-54, 19___, that I last saw the deceased alive on 7-28-54, 19___, and that death occurred at 12:58 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph M Schuster Jr MD 23b. ADDRESS 1515 Lafayette Avenue 23c. DATE SIGNED 7-29-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 7-30-54 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis County MO

DATE REC'D BY LOCAL REG. JUL 29 1954 REGISTRAR'S SIGNATURE J Earl Smith 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SUEBMEYER & SON'S 3934 N. 20th Street

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Gustav W. Dietz*

Licensed Embalmer No. *431*

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