

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32079

State File No.

FILED SEP 16 1954

BIRTH NO. 57191-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7882

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI		b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN POPLAR BLUFF	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS 705 DOVER ST.		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) LEE c. (Last) OVERSTREET			4. DATE OF DEATH (Month) (Day) (Year) JULY 16, 1954		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JULY 16, 1954	9. AGE (In years last birthday) 28	IF UNDER 1 YEAR Months 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME JOSEPH OVERSTREET		13b. MOTHER'S MAIDEN NAME BETTY GORDON		14. NAME OF HUSBAND OR WIFE NONE	
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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. NONE		17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asphyxia</u> <u>Prematurity</u> 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.			INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

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 7625	

22. I hereby certify that I attended the deceased from 7-16-54, 1954, to 7-16-54, 1954, that I last saw the deceased alive on 7-16-54, 1954, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Mary A. Davis, M.D.</u>		(Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 7-19-54					

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 8-31-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR Rowland Aker Monumental Services 4104 Manchester Ave.			
DATE REC'D BY LOCAL REG. AUG 26 1954		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		ADDRESS	

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.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.