

FILED JAN 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **42485**
Registrar's No. **11647**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		REGISTRAR'S NO. _____	
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 TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis,		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 BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 4937 Washington, 2129			
3. NAME OF DECEASED (Type or Print) a. (First) Alvin b. (Middle) J. c. (Last) Overbey			4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1955				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 22, 1889		9. AGE (In years last birthday) 66	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) Retired Owner		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (City and State or Foreign Country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Overbey		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Ruth Overbey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. 483614-1117		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth Overbey, 4937 Washington,			
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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of larynx with metastases ANTECEDENT CAUSES with metastases 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 yrs.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 161x		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) _____		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 Dec. 27, 1955 , to Dec. 31, 1955 , that I last saw the deceased alive on Dec. 31, 1955 , and that death occurred at 6:45A. m. , from the causes and on the date stated above.							
23a. SIGNATURE FR Bradley (Degree or title) M. D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 12/31/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-3-56	24c. NAME OF CEMETERY OR CREMATORY Wakewood Pk Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.		
DATE REC'D BY LOCAL REG. JAN 3 1956		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington,	

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

Student.....
Signature of Student Embalmer

Signed.....
Etienne P. Penule

Licensed Embalmer No. *42*.....

P. O. Address *St. Louis*.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (If 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.