

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED MAY 21 1956

State File No. **15758**

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **277**

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY STODDARD	
b. CITY OR TOWN CAPE GIRARDEAU		c. CITY OR TOWN BELL CITY	
c. LENGTH OF STAY (in this place) 40 DYS		d. STREET ADDRESS (If rural, give location) 1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL			

3. NAME OF DECEASED (Type or Print) O.P.A.	a. (First) O.	b. (Middle) P.	c. (Last) OVERBY	4. DATE OF DEATH (Month) (Day) (Year) MAY 12, 1956
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH DEC. 9, 1883	9. AGE (in years last birthday) 72	10 UNDER 1 YEAR Months	11 UNDER 24 HRS. Hours	12 UNDER 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) TILLMAN, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ROBERT B. OVERBY	13b. MOTHER'S MAIDEN NAME CORDELIA BOLLINGERT	14. NAME OF HUSBAND OR WIFE TOPSY OVERBY
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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 TOPSY OVERBY	ADDRESS BELL CITY, MO
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 hr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cocoonary artery disease DUE TO (c) Congestive failure		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial asthma			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **May 9, 1956**, to **May 12, 1956**, that I last saw the deceased alive on **May 11, 1956**, and that death occurred at **5:10 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles F. Wilson M.D.	23b. ADDRESS 744 Broadway Cape Girardeau Mo.	23c. DATE SIGNED 5-16-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5/13/56	24c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL CEME.	24d. LOCATION (City, town, or county) (State) STODDARD Mo. Mo.
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DATE REC'D BY LOCAL REG. 5-17-56	REGISTRAR'S SIGNATURE W. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE Mr. Lloyd S. Meyer, Jr.	ADDRESS Advance
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(Licensed Embalmer's Statement on Reverse Side)

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

9561 82 7062

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

W. H. Morgan

Licensed Embalmer No.

24640

P. O. Address

Advance, N.

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.