

# FEDERAL BUREAU OF INVESTIGATION

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 5 1960

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 502

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway 67</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Dunklin</u> c. CITY OR TOWN <u>Cardwell</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R F D</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Omer David Overbay</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Dec. 31 - 1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jul. 7 1939</u>	<b>9. AGE (last birthday)</b> <u>20</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Manufacturing</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Aircraft</u>		<b>11. BIRTHPLACE</b> (City, and state or country) <u>RFD Dunklin Co, Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Clarence H. Overbay</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Iva Barnes</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Single</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>			<b>16. SOCIAL SECURITY NO.</b> <u>430 72 2628</u>		<b>17. INFORMANT</b> Address <u>St. Francois Co.</u> <u>Mo. State Hgw Patrol, Mo</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Injuries received in automobile accident.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II if from (a).) <u>Injuries received when automobile collided with bridge.</u>			
<b>20c. TIME OF INJURY</b> Hour a.m. Month, Day, Year <u>11:50 p.m. Dec. 31, 1959</u>							
<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Public Highway</u>		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u>Near Flat River</u> <u>St. Francois</u> <u>Mo.</u>			
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at <u>11:45 p.m.</u> On the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22. SIGNATURE</b> (Degree or title) <u>Billy Miller Coroner</u>			<b>22b. ADDRESS</b> <u>Farmington, Mo</u>		<b>22c. DATE SIGNED</b> <u>1/2/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>		<b>23b. DATE</b> <u>12/31/1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Snow Gapwell Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Walnut Ridge, Arkansas</u> <u>Cardwell, Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>CZ Boyer &amp; Son Desloge, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>Jan. 2, 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Ethel Redloff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 11 1960

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 *D. T. Boyed*

Licensed Embalmer No. *3660*

P. O. Address *Keeloke*

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.