URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1960

-60-029385
STATE FILE NUMBER

Registration District No. 354 Primary Registration District No. 4519 Registrar's No. 62

NDED

1. PLACE OF DEATH
a. COUNTY Texas
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cabool — Length of stay in 1b: 2 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Texas
c. CITY OR TOWN Cabool — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) In Town — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First James Middle Monroe Last Overby

4. DATE OF DEATH: Month July Day 15 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Aug. 11, 1894
9. AGE (last birthday): 65 — IF UNDER 1 YEAR: Months 11 Days 4 — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister of the Gospel
10b. KIND OF BUSINESS OR INDUSTRY: Methodist
11. BIRTHPLACE (City and state or country): Dixon, Kentucky
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Thomas Overby
13b. MOTHER'S MAIDEN NAME: Cynthia Kavanaugh
14. NAME OF HUSBAND OR WIFE: Minnie B.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Minnie B. Overby Address: Cabool, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Essential Hypertension
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Nephritis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7/9/60, to 7/15/60 and last saw ~~her~~ him alive on 7/15/60
Death occurred at 9:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Garrett Hogg Jr MD
22b. ADDRESS: Cabool Mo.
22c. DATE SIGNED: 7/16/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: July 17, 1960
23c. NAME OF CEMETERY OR CREMATORY: Fair Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Henderson, Kentucky

24. FUNERAL DIRECTOR ADDRESS: Elliott-Gentry Funeral Home Cabool, Mo.
25. DATE RECD. BY LOCAL REG.: 7-19-60
26. REGISTRAR'S SIGNATURE: Gaynell Cunningham

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Earl Fapp

Licensed Embalmer No. 3458

P. O. Address Anderson,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.