

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16110

Registration District No. 1984

Primary Registration District No. 11

Registrar's No. 123

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis, Mo. Ref. N.Y.S.
 (c) Name of hospital or institution: St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Weeks
 (Specify whether years, months or days) 1 1/2

8. (a) PRINT FULL NAME Rudolph G. Overschmidt
 8. (b) If veteran, name war Unknown
 8. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nellie
 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased November 1 1888
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>5</u>	<u>24</u>	hr. min.

9. Birthplace Union Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business

MOTHER FATHER
 12. Name Joseph Overschmidt
 13. Birthplace Union, Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Francis Britenbach
 15. Birthplace Union, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Overschmidt
 (b) Address Union, Missouri

17. (a) Removal (b) Date thereof 4-27-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Mo.

18. (a) Signature of funeral director Dr. Albert H. Hoppe
 (b) Address 4700 Washington Ave.

19. (a) APR 27 1940 (b) R. Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County
 (c) City or town Union
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
 year 1940 hour 3 minute 33 p.m.

21. I hereby certify that I attended the deceased from March 18th, 1940, to April 25th, 1940;
 that I last saw him alive on April 25th, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death sarcoma of left buttocks with general metastasts. Duration

Due to
 Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy yes

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
 (e) Means of injury

23. Signature E. C. [unclear] (M. D. or other)
 Address 4101 Laclede Ave. Date signed 4/26/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. J. Sullivan

Licensed Embalmer No..... *1122*.....

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 this body is not embalmed, above space should be left blank.