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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24729

State File No.

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 295

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. 12 days (Specify whether years, months or days)
In this community 2 mos. 12 days

2. USUAL RESIDENCE OF DECEASED: 444
(a) State Indiana (b) County 15
(c) City or town Washington (If outside city or town limits, write "RURAL") 0
(d) Street No. 107 Sycamore (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Herman Louis OVERBAY
3. (b) If veteran, name war World War I
3. (c) Social Security No. 304-03-8473
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 27, 1889 (Month) (Day) (Year)

8. AGE: Years 53 Months 6 Days 19 If less than one day hr. min.

9. Birthplace Wheatland, Indiana (City, town, or county) (State or foreign country)
10. Usual occupation Meat Cutter
11. Industry or business "
FATHER
12. Name Louis Overbay
13. Birthplace Wheatland (City, town, or county) Indiana (State or foreign country)
MOTHER
14. Maiden name Melinda Nicholson
15. Birthplace Wheatland (City, town, or county) Indiana (State or foreign country)
16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-16-43 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Ind.
18. (a) Signature of funeral director HERBERT HOPE
(b) Address Excelsior Springs, Mo.
19. (a) 7-16-43 (Date received local registrar) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1943 hour 6:50 minute A. M.
21. I hereby certify that I attended the deceased from May 4, 1943 to July 16, 1943; that I last saw him alive on July 16, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis, pulmonary, chronic active, far advanced "4"	unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No autopsy	

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 name of place) Means of injury
23. Signature FORREST G. BELL, M. D. (M. D. or other)
Address Excelsior Springs, Mo. Date signed 7-16-43

(Licensed Embalmer's Statement on Reverse Side) VEterans Administration,

RECEIVED
District Health Officer No. 6,
District File Number
Date Filed 8-3-43

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 James A. Moles

Licensed Embalmer No. 3296

P. O. Address Excelsior Springs, Mo.

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.