

S. No. 2  
M-5-43  
7. 5-17-39  
I X36871

**FILED NOV 28 1945**

Registration District No. **23** Primary Registration District No. **3053** Registrar's No. **131**

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

1. PLACE OF DEATH:

(a) County **Shelby**

(b) City or town **Reed**

(c) Name of hospital or institution: **Wm. Garland Memorial**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **15 hrs.** (Specify whether years, months or days)

In this community **one week.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Atchison**

(c) City or town **Jarkio**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **James Overlease**

3. (b) If veteran **Spanish Amer** name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **mo** 5. Color or race **wh**

6. (a) Name of husband or wife **Wm. S. Overlease** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Feb. 15 1875**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **8**  
year **1945** hour **6** minute **30 AM**

21. I hereby certify that I attended the deceased from **Nov. 7, 1945**, to **Nov. 8, 1945**;  
that I last saw him alive on **Nov. 8, 1945**;  
and that death occurred on the date and hour stated above.

8. AGE: Years **70** Months **8** Days **23** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Myocardial degeneration** Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace **Shelby Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer - Retired**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Overlease**

13. Birthplace \_\_\_\_\_ 9

14. Maiden name **Anna Baum** 9

15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy **928**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant **Myrtha Stuebel**

(b) Address **Jarkio Mo**

17. (a) **Removal** (b) Date thereof **11-8-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jarkio Mo**

18. (a) Signature of funeral director **Wm. S. Overlease**

(b) Address **Reed Mo**

19. (a) **Nov. 10, 1945** (b) **Wm. J. Harney**  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_

Means of injury \_\_\_\_\_

23. Signature **Wm. S. Overlease** (M. D. or other) \_\_\_\_\_

Address **Reed Mo** Date signed **11-8-45**

DEC 6 1945

NOV 28 1945

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..... *S. L. [Signature]* .....

Licensed Embalmer No..... *3391* .....

P.,O. Address..... *Rollen 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.