

y. S. No. 2
ROOM-5-43
Rev. 5-17-39
I X34671

FILED SEP 14 1946

Registration District No. 147 Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether)

In this community 18 years
years, months or days

3. (a) PRINT FULL NAME John Robert Overman

3. (b) If veteran, name war World War 1

3. (c) Social Security No. 487-12-9737

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about	55			hr. _____ min.

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

10. Usual occupation Dispatcher

11. Industry or business A. B. C. Cab Co.

12. Name Silas Overman

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

14. Maiden name Fannie Elliott

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

16. (a) Informant Charles Overman

(b) Address Kaplan Missouri

17. (a) Removal Removal (b) Date thereof 9/3/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wadsworth, Kansas

18. (a) Signature of funeral director Dwight E. Ober

(b) Address 20 West Linwood

19. (a) 8-31-46 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1015 Washington
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28
year 1946 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from Aug. 23, 1946, to Aug. 28, 1946
that I last saw him alive on Aug. 28, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of liver

Due to _____

Due to _____

Other conditions 1245
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

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 Tom W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 8-28-46

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Dr. Green

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 *Edward W. Farmer*

Licensed Embalmer No. *4134*

P. O. Address *Kansas City, 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.