

FILED AUG 28 1948
Registration District No. **1003**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Earl Over**
3. (b) If veteran, name war.....
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married/
divorced Married
6. (b) Name of husband or wife.....
Elizabeth Over
6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased..... **June 21 1907**
(Month) (Day) (Year)

8. AGE: Years **41** Months **1** Days **22**
If less than one day
hr. min.

9. Birthplace..... **Fairmont Minn.**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Salesman**

11. Industry or business.....

MOTHER FATHER { 12. Name..... **Walter Over**
13. Birthplace..... **Ill.**
(City, town, or county) (State or foreign country)

14. Maiden name..... **Mills**
15. Birthplace..... **Garden City, Minn.**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mrs. Elizabeth Over (wife)**
(b) Address..... **6618 Clayton Ave.**

17. (a) **Burial** (b) Date thereof **8-14-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Lauri Hill Cemetery**

18. (a) Signature of funeral director..... **M. J. Croghan & Sons**

(b) Address..... **7246 Manchester Ave.**

19. (a) **AUG 14 1948** (b) **J. B. Bredack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6618 Clayton Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **13th**
year **1948** hour **1** minute **00** A. M.
21. I hereby certify that I attended the deceased from **3-31-48**
19... to **8-13-48** 19...
that I last saw h **im** alive on **8-13-48**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Capillary embolism of large bronchus**
Duration.....
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... **as above**
Of autopsy..... **as above**
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..... **M. Marvin Wallace** (M.D. or other)
Address..... **1515 Lafayette Avenue** Date signed..... **8-13-48**

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. Allen Davis, Jr.*
Licensed Embalmer No..... *4023*
P. O. Address..... *JT Davis*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept 25
7146
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Earl Over

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 32 years

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

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

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

10. Usual occupation Stakesman

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. J. Bredeek (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

28087

at 1-24