

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **38469**

FILED NOV 17 1953

BIRTH NO. _____ REG. DIST. NO. **52** PRIMARY REG. DIST. NO. **5183** Registrar's No. **57**

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|-----------------------------------|--|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If location: residence before admission.) | |
| a. COUNTY Cape Girardeau | b. CITY (If outside corporate limits, write RURAL and give town) Rural Byrd | a. STATE Missouri | b. COUNTY Cape Girardeau |
| c. LENGTH OF STAY (in this place) | d. FULL NAME OF HOSPITAL OR INSTITUTION H. M. W. Jackson | c. CITY (If outside corporate limits, write RURAL and give township) Rural Byrd | d. STREET ADDRESS (If rural, give location) 0169 |

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|--|---------------------|------------------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | (First) Carl | (Middle) Albert | (Last) Overbeck | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | Nov. 12-1953 |

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|------------------------|----------------------------------|--|--|--|---|--|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 15 1881 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months 6 Days 22 | IF UNDER 24 HRS. Hours Min. |
|------------------------|----------------------------------|--|--|--|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (State or foreign country) Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME August Overbeck | 13b. MOTHER'S M maiden name Caroline Vogelson | 14. NAME OF HUSBAND OR WIFE Bessie Overbeck |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Carmel Louise Overbeck Jackson | ADDRESS Jackson |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Sepsis | | INTERVAL BETWEEN ONSET AND DEATH 2 mo |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Septicemia | | |
| | DUE TO (c) None | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | 2043 |

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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
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22. I hereby certify that I attended the deceased from Feb 3, 1953, to Nov 12, 1953, that I last saw the deceased alive on Nov 10, 1953 and that death occurred at 7:20 AM., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) D. L. Substant | 23b. ADDRESS Jackson Mo. | 23c. DATE SIGNED 11-12-53 |
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|--|--------------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Nov. 14-1953 | 24c. NAME OF CEMETERY OR CREMATORY Russell Heights | 24d. LOCATION (City, town, or county) (State) Jackson Mo. |
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| DATE REC'D BY LOCAL REG. Nov 13-53 | REGISTRAR'S SIGNATURE D. L. Substant 43-0 | 25. FEDERAL DIRECTOR'S SIGNATURE Dorothea Laird Jackson | ADDRESS Jackson Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 11 1955

APR 28 1955

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *R. O. Laird*

Licensed Embalmer No. *4538*

P. O. Address *Jackson, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.