

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16409

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 268

Health,  
& Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Gir.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>South East Hosp., 7 da</u> Length of stay in 1b				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Gir.</u> c. CITY OR TOWN <u>Burfordville Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>Burfordville mo</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>-</u> Last <u>Frisch</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24 1878-79</u>	9. AGE (In years last birthday) <u>79</u> / <u>13</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>13</u> Hours <u>13</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife Keeping House</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Missouri</u>			
13. FATHER'S NAME <u>August Overbeck</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Vogelsang</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>now</u>		17. INFORMANT <u>Fritz Overbeck Jackson</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:- IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> DUE TO (b) <u>Carcinoma of transverse colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydromphrosis of right kidney</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>1 yr.</u>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>153X</u>					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <u>Sept. 25, 1956</u> to <u>May 7, 1957</u> and last saw <u>her</u> <del>him</del> alive on <u>May 7, 1957</u> Death occurred at <u>9:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>M. G. Smith M.D.</u>			22b. ADDRESS <u>1912 W. Broadway Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>5/10/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/8/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson Mo</u>		
24. FUNERAL DIRECTOR <u>Denese Faird Jackson</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>5-14-57</u>		26. REGISTRAR'S SIGNATURE <u>T. C. Summers</u>			

(Licensed Embalmer's Statement on Reverse Side)

4-0

**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 .....  
Signature of Student Embalmer

Signed *B. O. Rains* .....

Licensed Embalmer No. *453*

P. O. Address *Jackson*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.