

pt. Health,
c., & Welfare
S. Public
alth Service

Dr. S.P. Sargent
FILED VS MAY 27 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-022007
STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 132-193

v. S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> <u>90</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sikeston</u> <u>10032</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>703 Matthew</u>	Length of stay in lb <u>2 yr</u>	d. STREET ADDRESS (If outside, give location) <u>703 Matthew</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Jackson</u> Last <u>Overbey</u>			4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 29, 1894</u>	9. AGE (In years) UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months <u>64</u> Days <u>2</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Lamar Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Will Overbey</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Barnes</u>		13c. NAME OF HUSBAND OR WIFE <u>Jewel Overbey</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>492-42-1961</u>	17. INFORMANT Address <u>Mrs. John Moore Hayti, Mo.</u>	
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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>Coronary Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ 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>Asthma</u>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT <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 <u>Sikeston, Mo</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>4-30-60</u> to _____ and last saw her/him alive on <u>4-30-60</u> Death occurred at <u>5-16-60</u> <u>6:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Alden Sargent M.D.</u>	22b. ADDRESS <u>Sikeston, Mo</u>	22c. DATE SIGNED <u>5-17-60</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Dexter, Missouri</u>
24. FUNERAL DIRECTOR <u>John W. German</u>	ADDRESS <u>Hayti, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-17-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

MAY 27 1960

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 *John H. German*

Licensed Embalmer No. *4355*

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