WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Dent

Township: Springerets
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 266 File No. 32495

Primary Registration District No. 5370 Registered No. 41

[If death occurred in a hospital, or institution, give its NAME instead of street and number]

FULL NAME Henry N. Yeater

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Nov 1, 1831 (Month) (Day) (Year)

AGE: 81 yrs. 11 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

BIRTHPLACE (City or town, State or foreign country): Pike Co. Missouri

PARENTS
NAME OF FATHER: Joseph Boardman Yeater
BIRTHPLACE OF FATHER (City or town, State or foreign country): Burbon Co Ky
MAIDEN NAME OF MOTHER: Polly Penick
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Burbon Co. Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Yeater

(ADDRESS) Salem Mo.

Filed Oct. 3, 1912. J. C. Welch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 3, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 2, 1912 to Oct 2, 1912, that I last saw him alive on Oct 2, 1912, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: 11A 10-B 12

Marasmus following Severe Lagrippe

(Duration) ___ yrs. 9 mos. ___ ds.

Contributory (SECONDARY) Chronic Bronchitis

(Duration) 3 yrs. ___ mos. ___ ds.

(Signed) H. T. McMurtry M. D.

Oct 3, 1912 (Address) Salem Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 8 yrs. ___ mos. ___ ds. In the State 81 yrs. 11 mos. 3 ds.

Where was disease contracted if not at place of death? At place of death

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Jadwin Cemetery

DATE OF BURIAL: Oct 4, 1912

UNDERTAKER: N. D. Hobson

ADDRESS: Salem Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191...., to....., 191....,

that I last saw h.....alive on....., 191....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS