

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.

AUG 1 - 1934

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

Do not use this space.

Dr. McNeal

25894:1

File No. *25894:1*
Registered No. *25894:1*
St. _____ Ward _____

1. PLACE OF DEATH

County *Pettis* Registration District No. *672*
Township *Shedden* Primary Registration District No. *5895*
City _____ (No. *Sedalia RR & S.*)

2. FULL NAME

(a) Residence, No. *Sedalia Cont 3* St. _____ Ward _____

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *58* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mrs. Yeater</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Feb 18 1851</i>		
7. AGE YEARS <i>83</i>	MONTHS <i>5</i>	DAYS <i>8</i>
If LESS than 1 day, _____ hrs. or _____ min.		

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>farmer</i>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year) <i>life time</i>
	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

13. NAME *Yeater*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *D-K.*

15. MAIDEN NAME *D-K.*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *D-K.*

17. INFORMANT *Lee Yeater*
(ADDRESS) *Sedalia Cont 3*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Crown Hill* DATE *7-22-1934*

19. UNDERTAKER *Mc Laughlin Bros*
(ADDRESS) *Sedalia*

20. FILED *7-23-1934* *J. E. Evans*
Registrar.

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MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 20 - 1934*

22. I HEREBY CERTIFY, That I attended deceased from *July 20*, 1934, to *July 20*, 1934.
I last saw him alive on *July 20*, 1934. Death is said to have occurred on the date stated above, at *7:11* m.
The principal cause of death and related causes of importance were as follows:

Heart disease

Other contributory causes of importance:

*arteriosclerosis
chronic myocarditis*

Name of operation _____ Date of _____
What test confirmed diagnosis *Chloroform* Was there an autopsy? *yes*

23. If death was due to external causes (Violence), fill in also the following:
Accident, suicide, or homicide? *Heart disease* Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *Chambers*, M. D.

(Address) *Sedalia MO*

JUN 1 1949