

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**

Do not use this space.

5964

1. PLACE OF DEATH Linn
 County.....
 Registration District No. 496
 File No.....
 Township.....
 Primary Registration District No. 3025
 Registered No. 20
 City Brookfield (No., Brookfield Hospital St. Ward)
 2. FULL NAME Eva K. Yeager
 (a) Residence, No. 1003 N. Main St. 2 Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D.O. Yeager			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 12/1858			
7. AGE	YEARS	MONTHS	DAYS
76	6	6	1
			If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as splainer, sawyer, bookkeeper, etc. At Home		
	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).....		
			11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shannondale Ind.			
FATHER	13. NAME George Jones		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) do not know Pennsylvania		
MOTHER	15. MAIDEN NAME Sallie Sanford		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do Not Know Ky.		
17. INFORMANT Mrs. Maye Garrison (ADDRESS) Brookfield, Mo			
18. BURIAL, CREMATION, OR REMOVAL PLACE Kirksville, Mo. DATE 2/14/35			
19. UNDERTAKER C. White (ADDRESS) Brookfield, Mo.			
20. FILED 2-14 19 35 G. Lucas, M. D. Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/13/35**, 19**35**

22. I HEREBY CERTIFY, That I attended deceased from **1-31**, 19**35**, to **2/13/35**
 I last saw him alive on **2/13/35**, 19**35**. Death is said to have occurred on the date stated above, at **5:30 a.m.**
 The principal cause of death and related causes of importance were as follows:
Acute myocardial infarction
121
 Other contributory causes of importance:
Ph. hypertensive nephritis
 Date of onset **18hrs.**
2 yrs.

Name of operation..... Date of.....
 What test confirmed diagnosis **P. tub.** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... 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) **James M. Garrison**, M. D.
 (Address) **Brookfield, Mo.**

