

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38588**

Registration District No. **397**

Primary Registration District No. **1002**

Registrar's No. **4352**

1. PLACE OF DEATH: **3**
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **3 East 57th Street**
(d) Length of stay: In hospital or institution **about 12 years**
In this community **about 12 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **3920 Warwick**
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **JACOB O. YEAKLE 240**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Helen M. Yeakle** 6. (c) Age of husband or wife if alive **80 years**

7. Birth date of deceased **Feb. 21 1856**
(Month) (Day) (Year)

8. AGE: Years **83** Months **8** Days **22** If less than one day hr. m.in.

9. Birthplace **New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

12. Name **Malon M. Yeakle**

13. Birthplace **No Record**

14. Maiden name **Virginia Vinton**

15. Birthplace **No Record**

16. (a) Informant's own signature **Helen M. Yeakle**

(b) Address **3920 Warwick**

17. (a) **Burial** (b) Date thereof **Nov 15-1939**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**

18. (a) Signature of funeral director **John W. Wagner**

(b) Address **Kansas City, Mo.**

19. (a) **Nov 14 1939** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **13th**
year **1939** hour **10** minute **45** P.M.

21. I hereby certify that I attended the deceased from **2/14/39**
19....., to **11/13/39**, 19.....;

that I last saw him alive on **11/8/39**, 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

Due to **93c**

Due to

Other conditions **Arteriosclerosis Hypertension**

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **3**

While at work? (Specify type of place) (e) Means of injury

23. Signature **Dr. P. Brennan** (M. D. or other)

Address **714 Chambers** Date signed **11/13/39**

Dr. Richard O. Brennan
714 Chambers Bldg.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed A. R. Haunschild

Licensed Embalmer No. 4062

P. O. Address K.E. 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 this body is not embalmed, above space should be left blank.