

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. 1887

Registration District No. 253249

Primary Registration District No. 5170 B

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Cumbeo Co. Mo.
(b) City or town Rockland Mo.
(c) Name of hospital or institution: Anglaize Township.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) Life 3-11

8. (a) PRINT FULL NAME John Casyle Yadon
8. (b) If veteran _____ name war _____
8. (c) Social Security No. _____

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna E. Yadon
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased Feb 14th 1858
(Month) (Day) (Year)

8. AGE: Years 86 Months 10 Days 17 If less than one day hr. min.

9. Birthplace Rockland Laclede Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name William Preston Yadon

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Anneth Sumner

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Yadon

(b) Address 367 Sidney Ave. Maple Grove, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-1946
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director R. B. Super

(b) Address Rockland Mo. 119

19. (a) Jan 10 1946 (b) Mrs Mac Paul Munnig
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cumbeo
(c) City or town Rockland
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31
year 1939 hour 5:04 minute 20 AM

21. I hereby certify that I attended the deceased from 12-11, 1939, to 12-31-39, 1939
that I last saw him alive on 12-30-39 and that death occurred on the date and hour stated above.

Immediate cause of death arteria sclerodis
par. lesion of heart
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

23. Signature R. B. Super (M. D. or other) _____
Address Rockland Mo. Date signed 1-5-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

RECEIVED
District Health Officer No. 7,
District File Number 2-40-305
Date Filed 2-14-70

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 RB Ingers

Licensed Embalmer No. 3198

P. O. Address Richland M.

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.