S. No. 2
—11-10-39
v. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5284

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 509

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Research Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Days (Specify whether years, months or days) In this community 14 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton

(c) City or town Cole Camp (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ----- years.

3. (a) PRINT FULL NAME Dr. Homer P. Yeater 360

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Esther E. Yeater

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June (Month) 17 (Day) 1868 (Year)

8. AGE: Years 71 Months 7 Days 15 If less than one day ___ hr. ___ min.

9. Birthplace Albany (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Physician 1

11. Industry or business ----- 1

FATHER
12. Name John Yeater
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Martha Sampson
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Mrs Esther E. Yeater

(b) Address Cole Camp Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Albany, Missouri

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Feb. 3, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1st year ___ hour ___ minute ___ M.

21. I hereby certify that I attended the deceased from Jan. 17, 1940, to February 1, 1940; that I last saw him alive on January 31, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Staphococcic Septicemia

Due to Suppurative L. Epididymitis non specific 137

Due to Post operative from Trans Urethral Prostatic Resection Prostate Benign

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Uniform enlargement of all prostatic lobes —

Of autopsy Yes - Research Hosp Dept Pathology

Duration

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? (Specify type of place)

While at work? (e) Means of injury 1

23. Signature [signature] (M. D. or other)

Address 1019 Prof Bldg Date signed 2/2/40

(Licensed Embalmer's Statement on Reverse Side)

Professional 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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C 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.