

00000-17-39
Rev. 5-17-39
1 X10311

MAILED FOR INDEXING

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

12004

FILED APR 4 1940
Registration District No. 664

Primary Registration District No. 5883

State File No. _____
Registrar's No. 8

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Rural - Elk Fork Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Fifty years (years, months or days)

8. (a) PRINT FULL NAME HERMAN Yost

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ida Yost 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 27 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Lake Creek Township Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name John A Yost
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mary Yost (City, town, or county) (State or foreign country)
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willie Louise

(b) Address La Monte Mo

17. (a) Burial (b) Date thereof 3-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tabern Cemetery

18. (a) Signature of funeral director B. J. Parker

(b) Address La Monte Mo

19. (a) Mar 22, 1940 (b) W. R. Shelby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Platte
(c) City or town Elk Fork Rural
(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 March day 21 year 1940 hour 5 minute 20 PM.

21. I hereby certify that I attended the deceased from March 19, 1940 to March 21, 1940
that I last saw him alive on March, 19—;
and that death occurred on the date and hour stated above.

Immediate cause of death Chor myocorditis
Due to _____
Due to _____

Other conditions Chor nephritis (interstitial)
(Include pregnancy within 3 months of death) Influenza

Major findings: Of operations —
Of autopsy —
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? —

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

23. Signature M. W. Thrope (M. D. or other) MD
Address La Monte Mo Date signed Mar 22

RECEIVED
J. Edgar Hoover
Office No. 8
Date Filed
4-3-40
Filing Number

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 Paul M. Moore

Licensed Embalmer No. 3923

P. O. Address La Monte 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.