

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41868**  
Registrars No. **1312**

Registration District No. **85**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:  
 (a) County **BUCHANAN**  
 (b) City or town **ST. JOSEPH** **3**  
 (c) Name of hospital or institution: **STATE HOSPITAL No. 2**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **3 1/2 months**  
 In this community **3 years, 10 months, 26 days**  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **LOUISE YASECK**  
 (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex **female** 5. Color or race **white**  
 6. (a) Single, widowed, married, divorced **married**  
 (b) Name of husband or wife **Walker Yaseck** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **February 23 1903**  
 (Month) (Day) (Year)

8. AGE: Years **37** Months **9** Days **24** If less than one day  
 hr. \_\_\_\_\_ min \_\_\_\_\_

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

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

12. Name **W. Smith**

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

14. Maiden name \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant **Walker Yaseck**

(b) Address **1002 Bales, K.C., Mo.**

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

(c) Place: burial or cremation **State Hosp #2**

18. (a) Signature of funeral director **G. C. Staley**

(b) Address **602 S. 4th**

19. (a) **12/17/40** (b) **A. J. Keitt**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **1002 Bales**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **December** day **14** R  
 year **1940** hour **5** minute **7 a.m.**  
 21. I hereby certify that I attended the deceased from **July 1**  
 \_\_\_\_\_, 19**40** to **Dec. 13** R 19**40**  
 that I last saw her alive on **December 13** R 19**40**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia**

Due to **Tb. pulmon. cavity**

Due to **23**

Other conditions **Hydrocephalus, ext. and int.**  
 (Include pregnancy within 3 months of death)  
 Major findings: **None**  
 Of operations \_\_\_\_\_

Of autopsy **Tb. pulmon. Broncho-pneumonia, Hydrocephalus**

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

(a) Accident, suicide, or homicide (specify) **none**

(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? **85**

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

23. Signature **J. P. Burch** M. D. or other \_\_\_\_\_

Address **State Hosp #2** Date signed **12-15-40**

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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  
working under my personal supervision. *Max. Emb. 1/20/01*, Registered Apprentice No.

Signed *R. V. West*

Licensed Embalmer No. *3876*

P. O. Address *St. Joseph 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, fact should be so stated above.