

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. _____

Registration District No. 723

Primary Registration District No. 5956

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Center R F D
(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 Life _____
years, months or days

3. (a) PRINT FULL NAME Charles Lee Yager

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 Married

6. (b) Name of husband or wife Ida B Yager 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Nov 20 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer
11. Industry or business Own Farm

12. Name Joel H Yager

18. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Settles

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

16. (a) Informant's own signature W B Yager

(b) Address Center Mo

17. (a) Burial (b) Date thereof July 18 42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Norton Cemetery

18. (a) Signature of funeral director W B Yager

(b) Address Center Mo

19. (a) 7-17-42 (b) Mrs. Earl Perkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls

(c) City or town Center R F D
(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. ? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 16, 1942
year 6 hour 15 minute A M.

21. I hereby certify that I attended the deceased from Sept 1, 1941, to July 16, 1942,
that I last saw h / m alive on July 16, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart Disease
General Arteriosclerosis Duration 6100

Due to general Arteriosclerosis 104.

Due to 2

Other conditions (Include pregnancy within 3 months of death) 932

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? _____

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

23. Signature W B Norton (M. D. or other) _____
Address Summit Mo Date signed 7-16-42

RECEIVED
District Health Officer No. 10
DISTRICT HEALTH OFFICER
Date Filed 8-42-1942
AUG 11 1942

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.....

Licensed Embalmer No. 3356

P. O. Address Center, 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.