No. 2
—5-42
5-17739
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1689

FILED FEB 5 1943

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 80

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 114 Michel St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 years (Specify whether years, months or days)
In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 114 Michel St.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ray Yocum
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: ~~Trenton, Missouri~~ October (Month) 4 (Day) 1893 (Year)

8. AGE: Years 49 Months 3 Days 1 If less than one day hr. min.

9. Birthplace: Trenton (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Unemployed
11. Industry or business: None
MOTHER FATHER
12. Name: Newton Yocum
13. Birthplace: Platee Co., (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name: Franke Adkinson
15. Birthplace: Buchanan Co., (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Earl Yocum
(b) Address: Route # 6, St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Auburn Cemetery
18. (a) Signature of funeral director: John E. Rupp
(b) Address: 6054 Pryor Ave., City
19. (a) 1-8-43 (Date received by local registrar) (b) Rae Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5th 1943 year hour 5.30 A.M. minute M.
21. I hereby certify that I attended the deceased from Dec. 1st 1942, to Jan. 5th, 1943; that I last saw him alive on Jan. 4th 1943, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal obstruction,	2 Wks
Due to: Abdominal tumor.	?
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: No 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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Leroi Reik M.D. (M.D. or other)
Address: King Hill Bldg, St. Joseph, Mo. Date signed: 1/8/43

1235 (Licensed Embalmer's Statement on Reverse Side)

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

myself, Registered Apprentice No.

working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1689

Registration District No. 42 Primary Registration District No. 1002 Registrar's No. 80

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph (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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ray Yocum
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased: Oct (Month) 4 (Day) 1894 (Year)
8. AGE: Years Months Days If less than one day min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal obstruction — Duration
Due to: abdominal tumor probably malignant
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operation: No operation
Of autopsy: No 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature: Leroi Bockmeyer (M. D. or other)
Address: Krug Hotel Bldg St Joseph Mo Date signed 12/26/43

SUPPLEMENTARY