

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 20 1943

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

2271

1. PLACE OF DEATH:

(a) County St. Louis MO
 (b) City or town St. Louis MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Pronounced dead at City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME YARNALL, BENJAMIN3. (b) If veteran name war ✓ (c) Social Security No. 49-14-9036

4. Sex M. 5. Color or race W 6. (a) Single, widowed, married, divorced 1 M
 6. (b) Name of husband or wife CORA 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased FEB 9 1875
 (Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 28 If less than one day _____ hr. _____ min.9. Birthplace KENTUCKY (City, town, or county) (State or foreign country)10. Usual occupation SALES MAN11. Industry or business CONSOLIDATED HOME FURNISHING12. Name DONT KNOW YARNALL13. Birthplace DONT KNOW (City, town, or county) (State or foreign country)14. Maiden name DONT KNOW15. Birthplace DONT KNOW (City, town, or county) (State or foreign country)16. (a) Informant JOHN YARNALL(b) Address 3113^a LISMADE17. (a) ST. PETERS (b) Date thereof FEB 10 1943
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Peters18. (a) Signature of funeral director Private and Co.(b) Address 3710^a Grand Blvd19. (a) MAR 9 1943 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 17
 (c) City or town 3113^a LISMADE - 20
 (If outside city or town limits, write "RURAL")
 (d) Street No. St Louis
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country Attending Physician

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day March - 7
year 1943 hour 10 minute 30 A.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 _____ Duration _____

Coronary SclerosisDue to ArteriosclerosisDue to of H A

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

Major findings: Of operations _____

Of autopsy _____

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 Thomas J. Callahan M.D. (or other) _____Address Deputy Coroner Date signed 3-9-43

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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..... *Robert Brinkman*

Licensed Embalmer No..... *3553*

P. O. Address..... *7710 N. Grand*

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.