

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

32184  
Do not use this space.

FILED SEP 17 1943

1. PLACE OF DEATH

(a) County Waynes Registration District No. 237

(b) Township Center Primary Registration District No. 4353 Registered No. 31

(c) City Libon (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Alfred Yewell

(a) Residence, No. \_\_\_\_\_ (Usual place of abode, if no street address, write county or city) \_\_\_\_\_ (If nonresident, give city or town and State) \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Yewell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 27-1869

7. AGE YEARS 73 MONTHS 10 DAYS 0 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) 4 yrs 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrisburg, Pa.

13. NAME William Alfred

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Waynes, Mo.

15. MAIDEN NAME Anna Yewell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Waynes, Mo.

17. INFORMANT (ADDRESS) Almeda Jordan, Libon, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Stoodland, Mo. DATE Aug 29, 1943

19. FUNERAL DIRECTOR (ADDRESS) Waynes, Mo.

20. FILED 8-28-43, 19 Waynes, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 27, 1943

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1943 to Aug 27, 1943

I last saw him/her alive on Aug 26, 1943, 19 43 Death is said to have occurred on the date stated above, at 11:30 a.m.

The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis with failing compensation and dropsy. Date of onset \_\_\_\_\_

Other contributory causes of importance: 97a

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? Arterio Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury None 19 43

Where did injury occur? None (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) Bob Best, M. D. (Address) Libon, Mo.

RECEIVED

District Health Office No. 2,

District File Number 943-1136

Date Filed 9-13-43

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**