DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 4 1944

Registration District No. 360

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3076

State File No. 16050

Registrar's No. 50

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

**1. PLACE OF DEATH:**

(a) County Vernon

(b) City or town Nevada (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Nevada Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month (Specify whether

In this community ..... years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Vernon 108 1

(c) City or town Nevada 2 (If outside city or town limits, write "RURAL")

(d) Street No. 726 E. Lee (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country .....

**3. (a) PRINT FULL NAME** Willard Yates

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~~ 1

6. (b) Name of husband or wife Sadie Yates

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Nov. (Month) 21 (Day) 1855 (Year)

8. AGE: Years 88 | Months 4 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Oxford (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farming

11. Industry or business .....

FATHER
12. Name John Yates
13. Birthplace — (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name —
15. Birthplace — (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Sadie Yates

(b) Address Nevada, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 4 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pleasant

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Missouri

19. (a) 4-17-44 (Date received local registrar) (b) Hazel B. Beurck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month April day 1 year 1944 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from Mar 6, 1943 to Apr 1, 1944 that I last saw him alive on Apr 1, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia — Duration 5 days

Due to Dont Know.

Due to .....

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

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? ✓ (Specify type of place)

While at work? ✓ (e) Means of injury ✓

23. Signature W S Love (M.D. or other)

Address Nevada, Mo Date signed 4/1/44

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 4-44-579
Date Filed 5-3-44

**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~~ Me

, Registered Apprentice No.

working under my personal supervision.

Signed L. D. Ferry

Licensed Embalmer No. 1760

P. O. Address Kewanee, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

o. 2B
5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 1

**1. PLACE OF DEATH:**

(a) County Vernon

(b) City or town Nevada
(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 years, months or days)

**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 Willard Yates

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 M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. (Month) 21 (Day) 1855 (Year)

8. AGE: Years 88 Months 4 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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 April day

year 1944 hour minute M.

21. I hereby certify that I attended the deceased from

, 19 to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Broncho Pneumonia

Due to Don't know

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

Major findings:
Of operations

Of autopsy

Duration

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 W. Love (M. D. or other)

Address Date signed

SUPPLEMENTARY

160050