

22661

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
Registrar's No. 21

Registration District No. 392 Primary Registration District No. 3071

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater

(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution no

In this community 34 yrs

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Slater

(d) Street No. ....

(e) Citizen of foreign country? .....

If yes, name country .....

3. (a) PRINT FULL NAME Della Yowell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife S. T. Yowell

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased May, 7th 1885

(Month) (Day) (Year)

8. AGE: Years 59 Months 17 Days 17

If less than one day hr. .... min. ....

9. Birthplace Saline Co. Mo.

(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business .....

MOTHER FATHER { 12. Name Henry C. Coad Ind.

13. Birthplace Nancy Ann Cody Ind.

(City, town, or county) (State or foreign country)

14. Maiden name Nancy Ann Cody Ind.

(City, town, or county) (State or foreign country)

16. (a) Informant S. T. Yowell

(b) Address Slater, Mo.

17. (a) Burial (b) Date thereof 6/26/1944

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Slater, Mo.

(b) Address .....

19. (a) June 30-44 (b) Mrs. John G. Gugin

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th

year 1944 hour 6.30 minute a M.

21. I hereby certify that I attended the deceased from May 10 1944, to June 25 1944

that I last saw h. or alive on June 25 1944

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

Immediate cause of death Pulmonary Embolism & Cerebral Hemorrhage

Duration .....

Due to 2nd Cerebral Hemorrhage June 20-1944

Other conditions: gza

(Include pregnancy within 3 months of death)

Major findings: gza

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

(Specify type of place) .....

While at work? .....

Means of injury .....

23. Signature [Signature] (M. D. or ..)

Address Slater, Mo. Date signed July 1

District File Number  
Date Filed 7-8-47

JUL 2 1947

**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 Sam M Hill  
Licensed Embalmer No. 1292  
P. O. Address Slater 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.**