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25302

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI

BUREAU OF THE CENSUS

FILED AUG 15 1944

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 238

Primary Registration District No. 4355

Registrar's No. 24

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town New Madrid

(c) Name of hospital or institution: No

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

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

In this community unkn years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town New Madrid 72

(If outside city or town limits, write "RURAL") 4

(d) Street No. U

(If rural, give location)

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

If yes, name country U

3. (a) PRINT FULL NAME MIKE YARBRO

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex OM 5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 25 years 1885 (Year)

7. Birth date of deceased MAY 25 1885 (Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 3

If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name Joe Yarbros

13. Birthplace Becket Tenn (City, town, or county) (State or foreign country)

14. Maiden name Marj Fisher

15. Birthplace Becket Tenn (City, town, or county) (State or foreign country)

16. (a) Informant: Bertha Graves

(b) Address Parsons, Tenn

17. (a) Removal (b) Date thereof 7/29-44 (Month) (Day) (Year)

(c) Place: burial or cremation Parsons, Tenn

18. (a) Signature of funeral director Richard and Co

(b) Address New Madrid

19. (a) Aug 2-1944 (b) Helou Lou Jones (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1944 hour 3:00 minute a M.

21. I hereby certify that I attended the deceased from U 19U to U 19U

that I last saw h U alive on U and that death occurred on the date and hour stated above.

Immediate cause of death Ball hit head on concrete crushed skull on left side

Due to skull on left side

Due to U

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

Of autopsy U

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, which of the following:

(a) Accident, suicide, or homicide (specify) U

(b) Date of occurrence U

(c) Where did injury occur? (City or town) (County) (State) U

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

While at work? (Specify type of place) (e) Means of injury U

23. Signature Leo Hideruth Deputy Coroner

Address New Madrid, Tenn Date signed 7/31-44

1368

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 30 1944

RECEIVED

District Health Office No. 2

District File Number 844-1133

Date Filed 8-11-44

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

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*L. H. Hedgcock*

Licensed Embalmer No. 3803

P. O. Address

*New Madrid, 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AugRegistration District No. 238Primary Registration District No. 4355Registrar's No. 28

## 1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid  
(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 days3. (a) PRINT  
FULL NAMEMike Yarbco3. (b) If veteran,  
name war \_\_\_\_\_(c) Social Security  
No. \_\_\_\_\_4. Sex M  
5. Color or  
race W6. (a) Single, widowed, married,  
divorced \_\_\_\_\_6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased May 25 1918  
(Month) (Day) (Year)8. AGE: Years 59 Months 2 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1948  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

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

Immediate cause of death fall hit his head onconcrete curbshell on left side

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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) accident

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTAL INFORMATION REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

461 of 100

OCT 23 1944

25302