

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **149** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2635 Agnes
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 5 years
years, months or days

3. (a) PRINT FULL NAME James A. Yost

3. (b) If veteran, name war no 3. (c) Social Security No. 432-05-4306

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs Edna Yost 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Sept. 21st. 1875
(Month) (Day) (Year)

| | | | | |
|---------|-----------|----------|----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <u>69</u> | <u>4</u> | <u>3</u> | _____ hr. _____ min. |

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

10. Usual occupation Fruehauf Trailer Co

11. Industry or business I609 Locust

MOTHER FATHER { 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edna Yost
 (b) Address 2635 Agnes Kansas City Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 26-45
(Month) (Day) (Year)
 (c) Place: burial or cremation Omaha Neb.

18. (a) Signature of funeral director Eyalr Funeral Home
 (b) Address 1800 Linwood Kansas City Mo.

19. (a) 1-25-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 2635 Agnes
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24th
 year 1945 hour 5 minute P M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
 that I last saw h Brown alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Crown aneurysm

Due to arterio-sclerosis

Due to _____

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

Major findings:
 Of operations History + Angiogram
 Of autopsy no

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? _____ (c) Means of injury _____

23. Signature James Walker (M. D. or other) D. E. Brown
 Address 1424 Jefferson St Date signed 1-21-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MAR 8 1946

FEB 11 1946

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 Chas E. Wells

Licensed Embalmer No. 2644

P. O. Address Kansas City 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.