

FILED JAN 17 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

39

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Farmersville Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lake Side Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 7 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pass 19
(c) City or town Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Yuille

3. (b) If veteran, name war _____ 3. (c) Social Security No. 710

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Allie Yuille 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Mar 16 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Thomas Yuille
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Allie Yuille

(b) Address Hamilton Mo

17. (a) Burial (b) Date thereof Jan 6 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Bur. Mortuary

18. (a) Signature of funeral director Frank Yuille

(b) Address Hamilton Mo

19. (a) 1-4-45 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 1 day 4th
year 45 hour 10:28 minute 28 A. M.

21. I hereby certify that I attended the deceased from 12/28, 1944, to Jan 4, 1945
that I last saw him alive on Jan 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure Duration 2W

Due to Chronic Myo Cardia

Due to Age-Related

Other conditions _____
(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 D. C. Yuille (M.D. or other) Dr
Address 612 Charles St Date signed 1-4-45

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

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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 R. A. Brown

Licensed Embalmer No. 3052

P. O. Address Hamilton N

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.