

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 13 1945

Registration District No. 146

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

2479

Registrar's No. 13

Primary Registration District No. 3026

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Independence  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Independence Sanitarium  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 month  
 (Specify whether years, months or days) 4 3 years

3. (a) PRINT FULL NAME VERDA FLORENCE YOST3. (b) If veteran,  
name war None3. (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 Walter L Yost 6. (c) Age of husband or wife if  
alive 72 years  
 7. Birth date of deceased May 24 1871  
 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 20  
 If less than one day hr. min.

9. Birthplace Charcoal Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

## 11. Industry or business

12. Name William H. Thraill  
 13. Birthplace Fronton Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Florence  
 15. Birthplace Charcoal Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Walter L Yost(b) Address P.O. Independence Mo17. (a) Burial (b) Date thereof 1 17 45  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation W.D. Moriah18. (a) Signature of funeral director Geo G Carson(b) Address Independence Mo19. (a) 1-16-1945 (b) Thomas W. Cross  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
 (c) City or town Independence Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Leis Summit Road  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country U

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Dec 1  
 1945, to Jan 14, 1945  
 that I last saw her alive on Jan 14, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the esophagus Duration 1 yr  
 Due to \_\_\_\_\_

Due to 46  
 Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations none  
 Of autopsy none  
 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?

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature John P. Greene (M.D. or other)  
 Address Independence Mo Date signed 1-16-45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

REG-11-211950

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 *Floyd C. Benson*  
Licensed Embalmer No. *4199*  
P. O. Address *Independence, 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.**