

FILED AUG 9 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 227

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
State Hospital No 1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days)

In this community 18 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway 14

(c) City or town Adair City 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) 2

(e) Citizen of foreign country? n (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME. C. O. Yeater

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1945 hour 11 minute 30 P. M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 19 1954
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 28 1945, to July 16 1945, that I last saw him alive on July 16 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>61</u>	<u>5</u>	<u>29</u>	_____hr. _____min.

Due to Chr. Myocarditis + Asthma

Due to _____

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

10. Usual occupation laborer

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

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name John Yeater

13. Birthplace Louisiana Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Melissa Todd

15. Birthplace Louisiana Mo 1
(City, town, or county) (State or foreign country)

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) _____
(a) Means of injury _____

16. (a) Informant Anna Venable

(b) Address 153 Cedar Road Caldwell Mo 4

17. (a) Rural (b) Date thereof July 21-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital (should)

18. (a) Signature of funeral director G. G. Thomas

(b) Address 302 Market St. Fulton Mo

19. (a) 1-21-1945 (b) Joan M. [Signature]
(Date received local registrar) (Registrar's signature)

23. Signature John Thomas (M. D. or other) _____
Address Fulton Mo Date signed 7/16/45

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

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

14
1
2

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-7-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.