No. 2
-4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

28708

State File No.

FILED AUG 20 1945

Registration District No. 349 Primary Registration District No. 6152a Registrar's No. 20

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

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Dexter Mo. R3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Liberty
(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 days)

2. USUAL RESIDENCE OF DECEASED: 103
(a) State Missouri (b) County Stoddard
(c) City or town Dexter Mo R3
(If outside city or town limits, write "RURAL")
(d) Street No. Dexter, R.F.D.-3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John David Yocum
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Courzady Yocum
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased May 11 (Month) 1884 (Day) (Year)

8. AGE: Years 61 Months Days 16 If less than one day hr. min.

9. Birthplace Fairfield (City, town, or county) Ill (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Lafayette Yocum
13. Birthplace (City, town, or county) 2nd (State or foreign country)
MOTHER
14. Maiden name Ida McClure
15. Birthplace (City, town, or county) 2nd (State or foreign country)
16. (a) Informant Mrs Courzady Yocum
(b) Address Dexter Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29 45 (Month) (Day) (Year)
(c) Place: burial or cremation Stephens Cemetery
18. (a) Signature of funeral director Watkins Funl Hon
(b) Address Dexter Mo
19. (a) 7-1-45 (Date received local registrar) (b) Nora Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1945 hour 1.2 minute M.
21. I hereby certify that I attended the deceased from May 25, 1945 to May 27, 1945 that I last saw him alive on May 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia from Cancer Cold — Duration 4 days
Due to This Mon has been in bed for 6-7 years with
Due to muscular distrophy and Paralysis.
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
107

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 Dr Carlstan F. Dee (M.D. or other)
Address Malden Date signed May 29/45

1134

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 845-1063
Date Filed 8-8-45

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Chester 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.