S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42345

FILED JAN 11 1946

Registration District No. 3/6 Primary Registration District No. 6075 Registrar's No. 243

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington RURAL St. Francois Tp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 yrs. 3 mos. 17 das.
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Phelps 94
(c) City or town St. James 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DELLA M. YOWELL
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter E. Yowell
6. (c) Age of husband or wife if alive Age Unk. years
7. Birth date of deceased November (Month) 28 (Day) 1877 (Year)

8. AGE: Years 67 Months 11 Days 28 If less than one day hr. min.

9. Birthplace Texas County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name L. K. Wells
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Athalia Black
15. Birthplace Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. James, Mo.
18. (a) Signature of funeral director Licklider Funeral Home
(b) Address St. James, Missouri
19. (a) 12-7-45 (Date received local registrar) (b) Esther Rudolph (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26 year 1945 hour 9 minute 00 A. M.
21. I hereby certify that I attended the deceased from August 9, 1935, 19..., to November 26, 1945, 19...; that I last saw her alive on November 26, 1945, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	1 day
Due to	
Due to	
Other conditions Psychosis. S. Phase (Include pregnancy within 3 months of death)	16 yrs.
Major findings: Of operations	
Of autopsy No 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 0
23. Signature Ernest Hoch (M. D. or other)
Address Farmington Mo Date signed 11/9/45

1577 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 146-1538

Date Filed 1-9-46

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 Earl J. Miller

Licensed Embalmer No. 375-3

P. O. Address Farmington, 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.