

S. No. 2  
8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31167

State File No. ....

**FILED** OCT 7 1946  
286

Registration District No. ....

Primary Registration District No. 4424

Registrar's No. ....

1. PLACE OF DEATH: Peck

(a) County Humansville

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

(c) Name of hospital or institution: Demmitt Memorial Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

In this community 1 day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory 43

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

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

(e) Citizen of foreign country? x (Yes or No)

If yes, name country: .....

3. (a) PRINT FULL NAME DALE YEAGER

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 Edith

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Dec. 2, 1902  
(Month) (Day) (Year)

8. AGE: Years 43 Months 9 Days 12  
If less than one day hr. \_\_\_ min. \_\_\_

9. Birthplace Hickory Co. Mo. (1)  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business own farm

MOTHER FATHER

12. Name Homer Yeager

13. Birthplace Hickory Co. Mo. (1)  
(City, town, or county) (State or foreign country)

14. Maiden name Maude Washer

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

16. (a) Informant Homer Yeager

(b) Address Flemington Mo.

17. (a) Burial (b) Date thereof Sept. 17-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flemington Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Humansville Mo.

19. (a) Sept 19, 1946 (b) Lucile Kirkpatrick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14  
year 1946 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 13, 1946, to Sept 14, 1946  
that I last saw him alive on Sept 14, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Massive hemorrhage into left thigh

Due to: Rupture of left femoral vein

Due to: .....

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

Major findings: Of operations: [Signature]

Of autopsy: .....

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? 0 (Specify type of place) (c) Means of injury: .....

23. Signature [Signature] (M. D. or other) MD  
Address Humansville, Mo. Date signed 9/16/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

Dis

Dis

Date, filed

Officer No. 7,

9-16-994

10-4-46

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 me

Registered Apprentice No.

working under my personal supervision.

Signed

*E. H. Pinner*

Licensed Embalmer No.

42820

P. O. Address

*Avon, Ohio*

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.