

Registration District No. **274** Primary Registration District No. **3052**

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

1. PLACE OF DEATH:
 (a) County Pettis
 (b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Bothwell Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 days
(Specify whether years, months or days)
 In this community Entire life

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pettis **80**
 (c) City or town Sedalia **6**
(If outside city or town limits, write "RURAL")
 (d) Street No. 508 W. 7th **4**
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bertha Amelia Yost
3. (b) If veteran, name war _____ **(c) Social Security** No. _____

4. Sex Female **5. Color or race** white
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Chris **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased Aug. 12 1867
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 1
 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Bauer
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Rose Klab
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Jack H. Wilson
(b) Address Springfield Mo.

17. (a) Burial **(b) Date thereof** 4-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Mrs. Laughlin Bros.
(b) Address 515 So. Ohio Sedalia

19. (a) 4-14-47 **(b) Betty Yeager**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 13 **1947**
 year 1947 hour 12.55 minute P M.
21. I hereby certify that I attended the deceased from March 27
 1947, to April 13 1947.
 that I last saw her alive on April 13 1947.
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis
Auricular Fibrillation
 Due to _____
 Due to _____
 Other conditions: Fracture of Rt Femur - neck
(Include pregnancy within 3 months of death)
 Major findings: None
 Of operations _____
 Of autopsy: None

Duration
 ?
March 29
1947
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) Fell in home - 132
(b) Date of occurrence March 27 1947 - 6:30 am
(c) Where did injury occur? Home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Dropped on a rug
(Specify type of place) (e) Means of injury _____

23. Signature John B. Carlisle M.D. (M. D., certifier)
 Address Sedalia Mo Date signed 4-14-47

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-1-47

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

Philip M. McLaughlin

Licensed Embalmer No. 3729

P. O. Address Adelia, 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.