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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEP 16 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31800**  
Registrar's No. **12**

Registration District No. **198** Primary Registration District No. **4316**

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

1. PLACE OF DEATH:  
(a) County **Macon**  
(b) City or town **New Cambria**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **—**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 1/2 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Macon**  
(c) City or town **New Cambria**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **—** (If rural, give location)  
(e) Citizen of foreign country? **no.** (Yes or No)  
If yes, name country **—**

3. (a) PRINT FULL NAME **BENJAMIN B. YOCUM**  
3. (b) If veteran,  name war **—**  
3. (c) Social Security No. **—**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sep.** day **4**  
year **1947** hour **11** minute **20 A.** M.  
21. I hereby certify that I attended the deceased from **Sep 4<sup>th</sup> 1947** to **Sep 4<sup>th</sup> 1947**  
that I last saw him alive on **Sep 4<sup>th</sup> 1947**  
and that death occurred on the date and hour stated above

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Annie Yocum** 6. (c) Age of husband or wife if alive **75** years  
7. Birth date of deceased **October 27 1866**  
(Month) (Day) (Year)

Immediate cause of death **Droop in Paralysis** Duration **3 Days**

8. AGE: Years **80** Months **10** Days **7**  
If less than one day **—** hr. **—** min.

Due to **—**  
Due to **—**  
Other conditions (Include pregnancy within 3 months of death) **—**  
Major findings: Of operations **—**  
Of autopsy **no**

9. Birthplace **Schuyler County Ill.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Farmer**

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

MOTHER FATHER

11. Industry or business **—**  
12. Name **Jackson Yocum**  
13. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Louisa Clark**  
15. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Annie Yocum**  
(b) Address **New Cambria, Mo.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sep. 6, 1947**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **New Cambria Cemetery**  
18. (a) Signature of funeral director **H. J. Hillland**  
(b) Address **New Cambria, Mo.**  
19. (a) **Sept. 9** (Date received local Registrar) (b) **Josephine King** (Registrar's signature)

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 **Cocwell** (M. D. or other) **—**  
Address **New Cambria, Mo.** Date signed **Sept 6 1947**

RECEIVED  
District Health Officer No. 10  
District File Number 9-47-1234  
Date Filed SEP 15 1947

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 H. J. Gilleland  
Licensed Embalmer No. 4019  
P. O. Address New Cambria, 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.