

FILED OCT 21 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33257

Registration District No. 162

Primary Registration District No. 5595

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Jefferson
 (b) City or town Kimswick ROCK.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: RR #1 /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Years (Specify whether
 In this community Years years, months or days)

3. (a) PRINT FULL NAME THOMAS LEROY YOWELL

3. (b) If veteran, name war WW 1 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced IM

6. (b) Name of husband or wife *MARY* 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Aug 14 1892
 (Month) (Day) (Year)

8. AGE: Years 55 Months 10 Days 7 If less than one day hr. min.

9. Birthplace Little Rock Ark. (City, town, or county) (State or foreign country)

10. Usual occupation Telephone Operator

11. Industry or business Veterans Administration

12. Name Charles E. Yowell

13. Birthplace Ill (City, town, or county) (State or foreign country)

14. Maiden name Sarah May Eubanks

15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mary Yowell

(b) Address R #1 Kimmswick, Mo.

17. (a) Burial (b) Date thereof Oct. 15 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery
C. Hoffmeister Colonial Mortuary

18. (a) Signature of funeral director _____

(b) Address 646 Chippewa St.

19. (a) Oct 17 48 (b) Phil S. Kirk
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
 (c) City or town Kimswick
 (If outside city or town limits, write "RURAL")
 (d) Street No. RR #1
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12
 year 1948 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from FEB. 25, 1948, to OCT 12, 1948
 that I last saw him alive on OCT 11, 1948,
 and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHOPNEUMONIA Duration 2 DAYS

Due to _____

Due to _____

Other conditions ARTHRITIS, HYPERTROPHIC 30 YRS
 (Include pregnancy within 3 months of death)

MARIE-STROMPEL TYPE PHYSICIAN _____

Major findings: Of operations _____

Of autopsy IM

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 Al Harvey (M. D. or other) MD

Address 1116 LEMAY FERRY RD. Date signed 10-12-48

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

MOTHER FATHER

10-20-48
District Health Officer No. 3
RECEIVED

Dr. A. E. Harvey
222 Lemay Ferry

JUN 6 1949

NOV 8 1948

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

Linus C. Hoffmeister

Licensed Embalmer No.....

P. O. Address.....

7814 So Broadway

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.

Registration District No. 162

Primary Registration District No. 5095

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Kimberly
(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 _____
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas L. Youell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Aug 14
(Month) (Day) (Year)

8. AGE: Years 05 Months _____ Days _____ If less than one day _____
hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 14 Year 1948
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

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? _____
(City or town) (County) (State)

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

While at work? _____
(Specify type of place) (c) Means of injury

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

S-33357