

FILED APR 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

BIRTH NO. 49-012770 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 421

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (In this place) <u>18 days</u>		d. STREET ADDRESS (If rural give location) <u>2018 Scott St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hosp.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mark</u>	b. (Middle) <u>Stephens</u>	c. (Last) <u>Yarrington</u>	4. DATE OF DEATH (Month) (Day) (Year)	<u>4</u> <u>15</u> <u>49</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>28: Mar. 1949</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>15</u> Days <u>18</u> Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>St. Joseph Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Blaine J. Yarrington</u>	13b. MOTHER'S MAIDEN NAME <u>Marilyn F. Holt</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Blaine J. Yarrington</u> ADDRESS <u>St. Joseph Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Peritonitis acute</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Liver Abscess</u> DUE TO (c) <u>576x</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Autopsy findings as above</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 28, 1949 to April 15, 1949, that I last saw the deceased alive on Apr 15, 1949, and that death occurred at 2:15 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. Roger Moore M.D.</u>	23b. ADDRESS <u>St. Joseph Mo</u>	23c. DATE SIGNED <u>4-15-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/15/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City; town, or county) (State) <u>St. Joseph Mo</u>
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DATE REC'D BY LOCAL REG. <u>April 18, 1949</u>	REGISTRAR'S SIGNATURE <u>E. G. Jenkins 382</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bowman Funeral Home</u> ADDRESS <u>St. Joseph Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*D. Jones*  
*Emil*

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Eugene Wood*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. *3804*

P. O. Address *319 So 10th St. Joseph, 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.