

FILED SEP 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

27807

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>92</u>	
1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Pike</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Eolia</u>		<u>0825</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Pike County Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1/2 Mile North Post office</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Verl</u> b. (Middle) <u>Jean</u> c. (Last) <u>Yager</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 29, 1950</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 28 = 1926</u>	9. AGE (In years last birthday) <u>24</u>	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 6 HRS. Days <u>0</u>	Hours Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Elander Pyle</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Riley</u>		14. NAME OF HUSBAND OR WIFE <u>ALFRED L. Yager</u>			
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>494-22-8340</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Alfred L. Yager</u>		ADDRESS <u>Eolia, Mo</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Childbirth</u>						
	DUE TO (c) —						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NONE</u>					<u>6706</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		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 <u>5-9</u> , 19 <u>50</u> , to <u>8-29</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>8-29</u> , 19 <u>50</u> and that death occurred at <u>10:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> M.D.				23b. ADDRESS <u>Louisiana Mo</u>		23c. DATE SIGNED <u>8-29-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 31-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Eolia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Eolia Mo</u>		
DATE REC'D BY LOCAL REG. <u>Aug 30, 1950</u>		REGISTRAR'S SIGNATURE <u>Berniece Callier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McBee Funeral Service</u>		ADDRESS <u>Eolia, Mo</u>	

(Licensed Embalmers' Statement on Reverse Side) [Signature]

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

Date Received: SEP 9
DISTRICT HEALTH OFFICE
District File Number?
Date Filed: SEP 11 195

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.

Student
Student Embalmer

Signed *Norman E. Gosch*

Licensed Embalmer No. *2342*

P. O. Address *Edina 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.