

FILED NOV 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33994

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 86

0542
0

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Lexington</u>) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Higginsville</u> <u>0541</u> | |
| c. LENGTH OF STAY (in this place) <u>3 days</u> | | d. STREET ADDRESS (If rural, give location) <u>0</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> | | | |

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|-------------------------------------|---------------------------|---------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH |
| a. (First) <u>Mattie</u> | b. (Middle) <u>Wilson</u> | c. (Last) <u>Yingling</u> | (Month) (Day) (Year) <u>October-29-50</u> |

| | | | | | |
|----------------------|-------------------------------|---|--------------------------------------|---|--------------------------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u> | 8. DATE OF BIRTH <u>Dec. 3, 1868</u> | 9. AGE (In years last birthday) <u>81</u> Months <u>10</u> Days <u>26</u> | IF UNDER 1 YEAR Hours <u>26</u> Min. |
|----------------------|-------------------------------|---|--------------------------------------|---|--------------------------------------|

| | | | |
|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>our home</u> | 11. BIRTHPLACE (State or foreign country) <u>Corder, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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|---------------------------------------|--|--|
| 13a. FATHER'S NAME <u>John Wilson</u> | 13b. MOTHER'S MAIDEN NAME <u>Eliza Hollingsworth</u> | 14. NAME OF HUSBAND OR WIFE <u>Charles Yingling deceased</u> |
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|--|-------------------------------------|---|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>J. W. Frazer</u> | ADDRESS _____ |
|--|-------------------------------------|---|---------------|

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|---|---|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Low bowel obstruction-cause undetermined</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | <u>5705</u> Undetermined |
| | II. OTHER SIGNIFICANT CONDITIONS <u>Malnutrition</u> Conditions contributing to the death but not related to the disease or condition causing death. | | |

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|------------------------------------|--|--|
| 19a. DATE OF OPERATION <u>none</u> | 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 12-15-49 to 10-29-50, 19____, that I last saw the deceased alive on 10-28-50, 19____, and that death occurred at 12:40A m., from the causes and on the date stated above.

| | | |
|---|--|----------------------------------|
| 23a. SIGNATURE <u>Thomas B. Ben, M.D.</u> (Degree or title) | 23b. ADDRESS <u>Higginsville, Missouri</u> | 23c. DATE SIGNED <u>10-30-50</u> |
|---|--|----------------------------------|

| | | | |
|---|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>1030-50</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Macphelah</u> | 24d. LOCATION (City, town, or county) (State) <u>Lexington, Mo.</u> |
|---|--------------------------|---|---|

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| DATE REC'D BY LOCAL REG. <u>Nov 3-1950</u> | REGISTRAR'S SIGNATURE <u>M. M. ...</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. ...</u> ADDRESS <u>Higginsville, Mo.</u> |
|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 11-13-50

DISTRICT HEALTH OFFICE No. 3

District File Number -----

Date Filed ----- 11-13-50 -----

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.

NOV 11 1950

Signed Forrest A. Hooper

Signed -----
Student Embalmer

Licensed Embalmer No. 4358

P. O. Address Higginsville, 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.