

FILED MAR 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2635

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 292

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

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| 1. PLACE OF DEATH a. COUNTY BUCHANAN | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE WASHINGTON b. COUNTY CHELAN | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. JOSEPH | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CASHMERE, Rural 8460 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2926 FARAN ST. | | d. STREET ADDRESS (If rural, give location) P. R. # 1 | |

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|--|----------------------------|-------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) MATHILDA | b. (Middle) | c. (Last) YEAGER | 4. DATE OF DEATH (Month) (Day) (Year) 3-7-1951 |
|--|----------------------------|-------------|-------------------------|---|

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|-------------------------|----------------------------------|--|-------------------------------------|---|--------------------------------|--------------------------------|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 1-3-1880 | 9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|--|-------------------------------------|---|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (State or foreign country) PULO, NEBRASKA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME JOHN DEGEN | 13b. MOTHER'S MAIDEN NAME KRAMEL | 14. NAME OF HUSBAND OR WIFE AUGUST YEAGER |
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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) No | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME AUGUST YEAGER, CASHMERE, WASH | 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. | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years 331X |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arteriosclerosis | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 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 ~~announced~~ ^{viewed} the deceased from **on 3/8**, 19**51**, to _____, 19____; that I last saw the deceased alive on _____, 19____, and that death occurred at **8:45 P.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) H. F. Mundy, M.D. (Coroner) | 23b. ADDRESS St. Joseph, Mo. | 23c. DATE SIGNED 3/10/51 |
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|---|-------------------------------|---|---|
| 24. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 3-12-1951 | 24c. NAME OF CEMETERY OR CREMATORY Mount Olivet | 24d. LOCATION (City, town, or county) (State) St. Joseph, Mo. |
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| DATE REC'D BY LOCAL REG. Mar 16, 1951 | REGISTRAR'S SIGNATURE Carl C. Casper | 446 | 25. FUNERAL DIRECTOR'S SIGNATURE Ernest L. Jones | ADDRESS St. Joseph |
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APR 23 1951

NOV 8 1951

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 Victor Barry

Signed.....
Student Embalmer

Licensed Embalmer No. 14212

P. O. Address 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.