

STANDARD CERTIFICATE OF DEATH

Reg. #5518 SL #4074

FILED FEB 2 - 1955

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0107

1. PLACE OF DEATH a. COUNTY Illinois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Saint Clair	
b. CITY (If outside corporate limits, write RURAL and give town) 915 N. Grand, St. Louis, Mo.	c. LENGTH OF STAY (in this place) 12 days	c. CITY OR TOWN O'Fallon	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		STREET ADDRESS (If rural, give location) Route #2	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES	b. (Middle) T.	c. (Last) YAEGER	4. DATE OF DEATH (Month) (Day) (Year) January 5, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5/24/22	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 48 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY general	11. BIRTHPLACE (City and State or Foreign Country) O'Fallon, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Yaeger	13b. MOTHER'S MAIDEN NAME Ann Seip	14. NAME OF HUSBAND OR WIFE Virginia Yaeger
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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) Yes WW-2	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records, St. Louis, Mo.	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 Months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myelocytic Leukemia		
	ANTECEDENT CAUSES DUE TO (b) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
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 2041	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) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12/24**, 19 **54**, to **1/5**, 19 **55**, and that death occurred at **12:55A** m., from the causes and on the date stated above.

23a. SIGNATURE Franklin M. Booth M.D.	23b. ADDRESS VA Hosp., 915 N. Grand, St. Louis, Mo.	23c. DATE SIGNED 1/5/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-5-55	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) O'Fallon, Ill.
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DATE REC'D BY LOCAL REG. JAN 5 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wolfsberger-Meyer	ADDRESS O'Fallon, Il
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.