

10874

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAY 5 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 114

1. PLACE OF DEATH a. COUNTY <u>Adair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>7 wks</u>	c. CITY OR TOWN <u>Kirksville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Grim - Smith Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>109 E. Cottonwood</u> <span style="float: right;">0073 3</span>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nellie</u> b. (Middle) <u>Myrtle</u> c. (Last) <u>Yowell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 25, 1955</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 2, 1882</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____	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 <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>State of Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13a. FATHER'S NAME <u>Robert Calvin McMaster</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Huffman</u>		14. NAME OF HUSBAND OR WIFE <u>James I. Yowell</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James I. Yowell, Kirksville, Mo.</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</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) <u>332 X</u>			
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 attended the deceased from <u>3-9</u> , 19 <u>55</u> to <u>4-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>55</u> , and that death occurred at <u>5:10</u> a.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>E. A. Hudson M.D.</u>			23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>4-25-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/27/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>4-28-55</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joe M. Riley, Kirksville, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

0013

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 *George W. Davald*

Licensed Embalmer No. *479*

P. O. Address *Kirkman*

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.