

No. 300
10.48

FILED APR 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13995
State File No. _____

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 4316 Registrar's No. 93

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>	
c. LENGTH OF STAY (In this place) <u>53yrs.</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Raymond</u>	b. (Middle) <u>Ester</u>	c. (Last) <u>Yocum</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 7, 1956</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 13, 1905</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>II</u> Days <u>24</u>	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign, country) <u>Bynumville, Chariton Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Benjamin B. Yocum</u>	13b. MOTHER'S MAIDEN NAME <u>Anna O. Krager</u>	14. NAME OF HUSBAND OR WIFE <u>Loyola Yocum</u>
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>500-07-1832</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Grace Bevan, New Cambria, MO</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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Toxic Coma (Jaquemia)</u>		<u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute hepatic Insufficiency</u> DUE TO (c) <u>Chronic Portal cirrhosis</u>		<u>5-10 years</u> <u>5-10 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia, Asthma, Bronchopneumonia, Wind (15 years)</u>			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>5811</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from Jan 10, 1956, to April 7, 1956, that I last saw the deceased alive on April 7, 1956, and that death occurred at 3:4 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>William J. Freitas, D.O.</u>	23b. ADDRESS <u>New Cambria Missouri</u>	23c. DATE SIGNED <u>April 7, 1956</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr. 9, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Apr 10/56</u>	REGISTRAR'S SIGNATURE <u>Cathy Mcneely</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Killela</u>	ADDRESS <u>New Cambria Mo.</u>
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(Licensed Emballer's Statement on Reverse Side)

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

185

RECEIVED 4.18.56
MACON COUNTY HEALTH DEPARTMENT
County File No. 45663
Date Filed 4.19.56

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 A. J. Gilleland
Licensed Embalmer No. 4019

P. O. Address New Cambria 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.