

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 4 1957

STATE FILE NUMBER 30209
REGISTRATION DISTRICT NO. 318 PRIMARY REGISTRATION DISTRICT NO. 1003 REGISTRAR'S NO. 7695

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY MADISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fredericktown
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in lb 2 Days	3. STREET ADDRESS R.R. # 2
3. NAME OF DECEASED (Type or print) First Middle Last ROY SAMUEL YOHN			4. DATE OF DEATH 8-15-1957 Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Sewer	9. AGE (In years last birthday) 77 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Wentzville Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Yohn		14. MOTHER'S MAIDEN NAME Unknown	
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 Address Mrs. A. Benson 46 Chestnut
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus, pulmonary			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 177X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) Adenocarcinoma of prostate with metastases			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 10 August 57 to 15 August 57 and last saw him alive on 15 Aug 57 Death occurred at 8:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. Pearl Smith MD		22b. ADDRESS 1105 Central Clayton	22c. DATE SIGNED 16 Aug 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-19-1957	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kirkwood Mo.
24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich Webster Groves Mo.		25. DATE RECD. BY LOCAL REG. AUG 17 57	26. REGISTRAR'S SIGNATURE J. Pearl Smith, M.D. S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Barnes

Embark 10

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Leslie Welch*.....

Licensed Embalmer No. #.....

P. O. Address *Westerly, R.I.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.