

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012173

STATE FILE NUMBER

FILED MAY 11 1959

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 145

300  
1-57

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> COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Milan</u> 1050 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin</u>		Length of stay in 1b <u>5 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>Jackson Twp.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sharon Sue Yardley</u>			4. DATE OF DEATH Month Day Year <u>5 2 1959</u>
5. SEX <u>F m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1946</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>12</u> IF UNDER 1 YEAR Months Days <u>7 28</u> IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Milan - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13a. FATHER'S NAME <u>Julius Yardley</u>		13b. MOTHER'S MAIDEN NAME <u>Aldene Muller</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Julius Yardley</u> Address <u>Milan Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Chronic Rheumatoid Arthritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PROFOUND ANEMIA -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>59.2X</u>	
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 <u>3-30-59</u> to <u>5-2-59</u> and last saw her alive on <u>5-1-59</u> Death occurred at <u>1020 Am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Typed or title) <u>Earl Laughlin</u>		22b. ADDRESS <u>220 2<sup>nd</sup> Street, Milan, Mo</u>	
22c. DATE SIGNED <u>5-3-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>5-4-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Scobee Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Pollock - Mo</u>		24. FUNERAL DIRECTOR <u>Schoenes</u> ADDRESS <u>Milan Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>5-4-1959</u>		26. REGISTRAR'S SIGNATURE <u>Darwin W. Ratliff</u>	

All diseases in Part I must be correctly related.  
EARL LAUGHLIN  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Dwight Schone* .....

Licensed Embalmer No. *2667* .....

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