

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-041130**

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. 261 Primary Registration District No. 3048 Registrar's No. 275

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Nodaway</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Maryville</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Nodaway</u>
Length of stay in lb <u>1 mo. 10 days</u>		c. CITY OR TOWN <u>Maryville</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>		d. STREET ADDRESS <u>703 S Main</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>	
First <u>JOHN</u>	Middle <u>EDWARD</u>	Last <u>YAHRMARK</u>	Month <u>11</u>	Day <u>29</u>
Year <u>1959</u>				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/31/1882</u>	<b>9. AGE (last birthday)</b> <u>77</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ret farmaer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farming</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Graham, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
<b>13a. FATHER'S NAME</b> <u>August Yahrmark</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Amelia Walters</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Beulah Yahrmark</u>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>	<b>17. INFORMANT</b> <u>Mrs Mabel Peterson, Arcadia, Calif.</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u>	<u>?</u>
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	
DUE TO (b)	
DUE TO (c)	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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21. I attended the deceased from 10/18/59 to 11/28/59 and last saw her alive on 11/28/59  
Death occurred at 4:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>J. Byland M.D.</u>	<b>22b. ADDRESS</b> <u>Maryville Mo</u>	<b>22c. DATE SIGNED</b> <u>12/1/59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>	<b>23b. DATE</b> <u>12/1/1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Miriam Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) <u>Maryville, Mo.</u>
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<b>24. GENERAL DIRECTOR</b> <u>McCluskey</u>	<b>ADDRESS</b> <u>Maryville, Mo. 12-1-59</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-1-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Beas Hult</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 G. M. C. [Signature]

Licensed Embalmer No. 2279

P. O. Address [Signature]

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.