

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-60-034264
STATE FILE NUMBER

FILED VS SEP 3 0 1960

Registration District No. 86 Primary Registration District No. 5322 Registrar's No. 24-1960

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BENTON Twp</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u> ⁰²⁸⁰²
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT Home</u>		Length of stay in lb <u>6 mos</u>	d. STREET ADDRESS (If outside, give location) <u>STAR ROUTE</u>
90		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JANIA</u> Middle <u>AUGUSTA</u> Last <u>YANCLEAVE</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>19</u> Year <u>1960</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 22 1874</u>	9. AGE (In years last birthday) <u>86</u>	10. UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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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 country) <u>Steelville Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Christian Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Jonathan Yancleave Deed.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wgt or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Almed Rippon</u>	Address <u>Cuba Mo</u>
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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>CARDIAC DECOMPENSATION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	
	DUE TO (c) <u>4221A</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PULMONARY TUBERCULOSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u></u>
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	
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20d. INJURY OCCURRED WHILE AT <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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from 1955 to SEP 19-60 and last saw her alive on SEP 18-1960
Death occurred at 2:35 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert J. Sullivan</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Sullivan Mo.</u>	22c. DATE SIGNED <u>Sept 20-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SAFFRAY</u>	23d. LOCATION (City, town, or county) (State) <u>Cuba Mo.</u>
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24. FUNERAL DIRECTOR <u>Norman C. Hoener</u>	ADDRESS <u>Cuba, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-22-1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Norman A. Haines*
Licensed Embalmer No. *4673*
P. O. Address *Cuba, 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.