

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034508

LEB VS SEP 26 1960

Registration District No. 128 Primary Registration District No. 965 Registrar's No. 967

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 47 yrs.	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunshine Acres		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1054 West State		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRA Middle ANNA Last YOAKUM			4. DATE OF DEATH Month Sept. Day 19 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/9/92	9. AGE (last birthday) 68
IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 1 YEAR Hours	IF UNDER 24 HR Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) West Point, Ga.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Thomas Rogers		13b. MOTHER'S MAIDEN NAME Dollie Hadaway		14. NAME OF HUSBAND OR WIFE Shelby Yoakum	
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. Unknown	17. INFORMANT 1054 W. State Shelby Yoakum Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Disease					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____				
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 1959 to Sept. 19, 1960 and last saw her Sept. 14, 1960 alive on Sept. 14, 1960 Death occurred at 3:40 a. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Lyman Brown, MD			22b. ADDRESS 311 1/2 College Springfield, Missouri		22c. DATE SIGNED 9/20/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/21/60	23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	23d. LOCATION (City, town, or county) (State) Springfield, Missouri		
24. FUNERAL DIRECTOR Ayre-Goodwin		ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 9-20-60	26. REGISTRAR'S SIGNATURE Effie E. Nelson	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

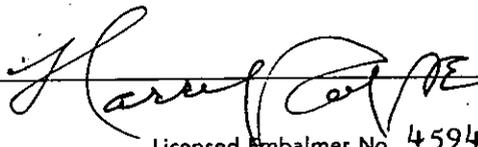
NOV 7 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 4594

P. O. Address Springfield

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