

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042623

FILED VS DEC 13 1960

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. Registrar's No. 180

1. PLACE OF DEATH a. COUNTY LACLEDE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY ARCADE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN UNION TWP		Length of stay in 1b 2 YRS	c. CITY OR TOWN CONWAY MO		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION NONE			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1 MI NW	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS EARL YESTAL			4. DATE OF DEATH Month Day Year NOV 30 1960		
5. SEX MALE	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 4-14-1895	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME THOMAS YESTAL		13b. MOTHER'S MAIDEN NAME MARY RUSSELL		14. NAME OF HUSBAND OR WIFE CARRY	
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. 499-40-8109	17. INFORMANT Address CARRY YESTAL CONWAY 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) CIRCULATORY FAILURE DUE TO (b) CORONARY THROMBOSIS DUE TO (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Immediate
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 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>11/30/60</u> to <u> </u> and last saw him alive on <u>11/30/60</u> Death occurred at <u>545 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) [Signature]		22b. ADDRESS Marshallfield, Mo.		22c. DATE SIGNED 12/3/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-30-1960	23c. NAME OF CEMETERY OR CREMATORY HAPPY HOME		23d. LOCATION (City, town, or county) (State) WEBSTER CO MO
24. EMBALMER'S NAME BARBER-EDWARDS		25. DATE RECD. BY LOCAL REG. 12-3-1960		26. REGISTRAR'S SIGNATURE Hella L. Day	

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

George Stapp

Licensed Embalmer No. 346

P. O. Address Mt. Green

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.