

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010170

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 26

AMENDED

FILED MAR 30 1961

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Subastian</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville</u>		c. CITY OR TOWN <u>Fort Smith</u>	
Length of stay in 1b <u>4 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>----</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Keavin</u> Middle <u>Tracy</u> Last <u>Yates</u>			4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Jan 18 1961</u>	9. AGE (last birthday) <u>1</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Fort Smith Ark.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Dwight S Yates Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Edna B Yates Webb</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dwight S Yates</u>		Address <u>Crocker 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>BRONCHIAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
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 (a) <u>6 weeks premature infant</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 Month, Day, Year _____ Hour 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.) <u>✓</u>	20f. CITY, TOWN, OR LOCATION <u>Crocker, Missouri</u>		STATE <u>Missouri</u>

21. I attended the deceased from MARCH 2, 1961 to MARCH 7, 1961 and last saw him alive on MARCH 7, 1961
Death occurred at 10:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John A. Mihalic</u> DO		22b. ADDRESS <u>Crocker, Missouri</u>		22c. DATE SIGNED <u>3/8/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fort Leonard Wood Mo</u>
24. FUNERAL DIRECTOR <u>Moss-Williams</u>		ADDRESS <u>Crocker Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-8-61</u>
26. REGISTRAR'S SIGNATURE <u>Eula Mae Anderson</u>				

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 Clarine J. Ross

Licensed Embalmer No. 4896

P. O. Address Waynesville, 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.