MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-027950
STATE FILE NUMBER

AMENDED

FILED JUL 19 1961

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1863

1. PLACE OF DEATH
a. COUNTY St. Louis Co.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Affton — Length of stay in 1b HRS.
c. FULL NAME OF HOSPITAL (If NOT in hospital, give location) OR INSTITUTION Henninger Nursing Home — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY ST Louis
c. CITY OR TOWN Lemay — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 2820 Oledel Rd. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Ida Middle Yaggi Last
4. DATE OF DEATH Month July Day 4 Year 1961.
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH Mar 18-1883
9. AGE (last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Tennessee
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME M. McClearen
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Wm V. Yaggi
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no.
17. INFORMANT Louise Marshall Address 2820 Oledel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 12 hrs
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)
dysphagia; left hemiparesis due to cerebral thrombosis —
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 1, 1961 to July 4, 1961 and last saw her alive on July 4, 1961
Death occurred at 9:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE John C. Cavell (Degree or title) M.D.
22b. ADDRESS 9764 Tesson Ferry Rd
22c. DATE SIGNED 7/5/61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL.
23b. DATE 7-7-61
23c. NAME OF CEMETERY OR CREMATORY Sunset Bur Pk.
23d. LOCATION (City, town, or county) (State) St. Louis Co Mo.
24. FUNERAL DIRECTOR Witt Bros L & H. Co. ADDRESS 6409 Gravois
25. DATE RECD. BY LOCAL REG. 7-5-61
26. REGISTRAR'S SIGNATURE John G. Murphy M.D.
(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

ITEM NO. | SHOULD READ | INSTEAD OF | DOCUMENT | DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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_____ Signed Harvey Kahle

Signature of Student Embalmer

Licensed Embalmer No. 4596

P. O. Address St Louis 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.