

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002678

AMENDED

Registration District No. 206 Primary Registration District No. 3040 Registrar's No. 8

STATE FILE NUMBER

FILED JAN 31 1962

1. PLACE OF DEATH a. COUNTY Madison		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fredericktown		Length of stay in 1b 19 days	c. CITY OR TOWN St. Michaels Township Rural
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Madison Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1 Mile N. of Fredericktown
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Sarah Middle Clarenza Last Yancey	4. DATE OF DEATH Month January Day 23 Year 1962
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1882	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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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) Gary, Indiana	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Francis	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND (If deceased) J.L. Yancey (deceased)
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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. None	17. INFORMANT Address James M. Yancey - Fredericktown, Missouri
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Mediastinal Emphysema		5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Broncho - mediastinal. Fistula	5 minutes
	DUE TO (c) Pulmonary Emphysema	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (a) Generalized Arteriosclerosis with Coronary and Cerebral occlusion		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

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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
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21. I attended the deceased from **Jan. 9, 1962** to **Jan 23, 1962** and last saw her ^{him} alive on **Jan 23, 1962**
Death occurred at **9:45 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) T. Thomas Warren, M.D.	22b. ADDRESS 115 So. Wood, 7th St. Fredericktown, Mo.	22c. DATE SIGNED Jan. 23, 62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 25, 1962	23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	23d. LOCATION (City, town, or county) (State) Madison County, Missouri
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24. FUNERAL DIRECTOR J. J. Harrison	ADDRESS Fredericktown, Mo.	25. DATE RECD. BY LOCAL REG. 1-25-1962	26. REGISTRAR'S SIGNATURE Herence Sticha
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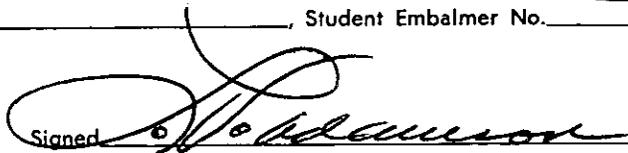
(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED **3/8/62**
 ITEM NO. **18c** Pulmonary emphysema
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF attending physician **Mediastinal adenopathy**

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  _____

Licensed Embalmer No. 4351

P. O. Address FREDERICKTOWN

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.