

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-037993

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 175

FILED OCT 30 1962

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville, Mo</u> Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin J. Yoder</u>			4. DATE OF DEATH Month Day Year <u>October 15 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/37</u>
9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cass Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
11. BIRTHPLACE (City and state or country) <u>Cass Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Christian L. Yoder</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gerber</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary A. Yoder</u>		17. INFORMANT Address <u>Mary A. Yoder, Harrisonville, Mo</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>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Cardiac Insufficiency</u> DUE TO (c) <u>2 yrs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 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 checked="" 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>4/10 1955</u> to <u>Oct 15</u> and last saw ^{him} alive on <u>Oct 15</u> Death occurred at <u>4:10</u> <u>PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. E. Frosch, M.D.</u>		22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>10/16/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clearfork Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cass Co., Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>A. D. Wartzler East Lynne Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-23-62</u>	26. REGISTRAR'S SIGNATURE <u>Roy G. Seber</u>

(Licensed Embalmer's Statement on Reverse Side)

NOV 28 1966

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

Robert W. Atkinson

Licensed Embalmer No.

4902

P. O. Address

Haverhill, MA

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.