

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-045730  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 373 Primary Registration District No. 6770 Registrar's No. 56

<b>FILED NOV 26 1962</b>	
1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>UNION TWP</b> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b> c. CITY OR TOWN <b>NIANGUA</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>6 MI EAST</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CHARLES A</b> Middle <b>YESTAL</b> Last <b>YESTAL</b>			4. DATE OF DEATH Month <b>NOV</b> Day <b>2</b> Year <b>1962</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-1884</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PET FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
13a. FATHER'S NAME <b>TOM YESTAL</b>		13b. MOTHER'S MAIDEN NAME <b>MAV RUSSELL</b>		14. NAME OF HUSBAND OR WIFE <b>CORA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>CORA YESTAL NIANGUA</b> Address _____

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) <b>CONGESTIVE HEART FAILURE</b>		<b>6 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>	<b>20 YRS.</b>
	DUE TO (c) <b>AND ANEMIA OF UNDETERMINED ORIGIN</b>	<b>UNKNOWN</b>

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
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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 Hour _____ a.m. _____ 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 _____

21. I attended the deceased from 10-29-62 to 11-2-62 and last saw her alive on 11-2-62  
 Death occurred at 4:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Robert J. Barber, M.D.</b> (Degree or title)	22b. ADDRESS <b>Marshfield, Mo</b>	22c. DATE SIGNED <b>11-6-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-4-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GOOD SPRINGS</b>	23d. LOCATION (City, town, or county) (State) <b>WEBSTER, CO MO</b>
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24. FUNERAL DIRECTOR <b>BARBER-EDWARDS</b>	ADDRESS <b>MARSHFIELD</b>	25. DATE RECD. BY LOCAL REG. <b>11-17-62</b>	26. (REGISTRAR'S SIGNATURE) <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
1 1120
2 1120
3
4 0
5 1
6
7 0
8 2
9 4200
10
11
12 90-0
13 3-0

**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. 3848

P. O. Address Mt. Airy, N.C.

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.