

AUG 22 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25756
Do not use this space.

1. PLACE OF DEATH

(a) County Haskell Registration District No. 384
(b) Township Benton Primary Registration District No. 5538 Registered No. _____
(c) City Mary, Mo. (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Mary Elizabeth Yeager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fu 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. H. Yeager

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 11 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 5 14

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
9. Industry or business in which work was done, as saw mill, bank, etc. housewife
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Co. Mo.

FATHER 13. NAME Ed Butts

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk

MOTHER 15. MAIDEN NAME unk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk

17. INFORMANT (ADDRESS) Mrs. Walter Faraway

18. BURIAL, CREMATION, OR REMOVAL PLACE Mary DATE 6/26

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Group

20. FILED 7-10 1939 Vida H. SIMONS Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/35 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-7-1939 to 6-25-1939

I last saw him alive on 6-7-1939 death is said to have occurred on the date stated above, at 2:20 pm.

The principal cause of death and related causes of importance were as follows:

Free cut, Dorsal & crushed shoulder & arm caused by stroke of paralysis of some type. I can't see very much about it.

Other contributory causes of importance:

Name of operation Stent Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. H. Faraway, M. D.

34 (Address) Viola

RECEIVED

District Health Officer No. 5,

District File Number 839 66

Date Filed 8/10/39

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.