

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH

State File No. _____

31338

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3436

1. PLACE OF DEATH: 1

(a) County Jackson

(b) City or town 11 E. Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 11 E. Gen Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

In this community 20 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State MO (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1402 Elmwood
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Walter Yard 63

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1939 hour 6 minute 45-8 M.

21. I hereby certify that I attended the deceased from Aug 27-1939, 1939, to Aug 29, 1939 that I last saw him alive on Aug 29-39 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife MRS WILHEMANA YARD

6. (c) Age of husband or wife if alive DEAD years 25-1868

7. Birth date of deceased (Month) Aug (Day) 25 (Year) 1868

Immediate cause of death Acute Pulmonary Congestion and Edema Duration _____

Due to Acute Dilatation of Heart

Due to Chronic Myocardial Sclerosis

Other conditions (include pregnancy within 3 months of death) 92c

8. AGE: Years 72 Months 3 Days 4 If less than one day hr. _____ min. _____

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation Laborer

Major findings: Of operations none

Of autopsy See above

PHYSICIAN _____ Underline the cause to which death should be charged statistically

MOTHER FATHER

11. Industry or business _____

12. Name Marion Yard

13. Birthplace Jesse

14. Maiden name Leann Thompson

15. Birthplace MO

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature A. D. De Marco M.D. or other _____
Address Capt. H. C. Gen. Hosp Date filed _____

16. (a) Informant's own signature Reginald Clerk

(b) Address H. C. Gen Hosp

17. (a) BURIAL (b) Date thereof SEPT. 1-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director D. H. Newcomb's Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 9-1-39 (b) W. M. Mearns
(Date received local registrar) (Registrar's signature)

REV. 8-17-39 I X19311

1-39

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 Emile M. Colborn
Licensed Embalmer No. 3506
P. O. Address K. C. N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

31338
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township K.C. Primary Registration District No. 1002 Registered No. 3436
(c) City K.C. (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 Walter yard

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-25-1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hra. or _____min.
71 7/2 3 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 1, 1929 M. M. Browne Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the day stated above, at _____ m.

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

Date of onset

Other contributory causes of importance:

Name of operation _____ 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 _____

Nature of injury _____

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

If so, specify _____ (Signed) P. J. Demaria, M. D.

(Address) Supt. Gen. Hosp.

N.B. - In case of information which should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRAR - ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

