

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 10 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42010**
Registrar's No. **332**

Registration District No. **104** Primary Registration District No. **3008**

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

1. PLACE OF DEATH:

(a) County **Callaway**

(b) City or town **Fulton**

(c) Name of hospital or institution: **State Hospital # 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 mos - 10 days**
(Specify whether)

In this community **3**
years, months or days

3. (a) PRINT FULL NAME **Margaret Yeager**

3. (b) If veteran, name **DIS.**

3. (c) Social Security No. **DIS.**

4. Sex **Female**

5. Color or race **white**

6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **HUGUST YEAGER**

6. (c) Age of husband or wife if alive **1, 1865**

7. Birth date of deceased: **Oct.**
(Month) (Day) (Year)

8. AGE: Years **75** Months **2** Days **8**

If less than one day
hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Henry Rapien**

13. Birthplace **OK DIS**
(City, town, or county) (State or foreign country)

14. Maiden name **D.K.**

15. Birthplace **OK OK**
(City, town, or county) (State or foreign country)

16. (a) Informant **State Hosp # 2 Records**

(b) Address **Fulton, MO**

17. (a) **Removed** (b) Date thereof **12/10/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Method # 1 2/12/40**

18. (a) Signature of funeral director **W.B. Miller**

(b) Address **Callaway**

19. (a) **Dec 10, 1940** (b) **R.N. Crewe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **City of St. Louis**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **1416-d FERRER**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **12/10/40**
year **1940** hour **3** minute **15 A** M.

21. I hereby certify that I attended the deceased from **Oct 4**
_____, 19**40**, to **DEC 10**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis and Myocardial Degeneration**

Due to _____

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? **106**

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Geo F. Wood** (M. D. or other) **MD**

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

NOV 19 1947

FEB 26 1942

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, fact should be so stated above.