

FILED MAR 25 1941 **791**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **1671**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town Rural
 (c) Name of hospital or institution:
11149 Riverview Blvd.
 (d) Length of stay: In hospital or institution.....
 In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County 000
 (c) City or town Rural
 (d) Street No. 11149 Riverview Blvd.
 (e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Frank Theodore Yeager

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna E. Yeager 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Feb 6 1867

8. AGE: Years 74 Months 0 Days 15 If less than one day hr. min.

9. Birthplace St. Louis, Mo.

10. Usual occupation Police Officer

11. Industry or business Retired

12. Name John Yeager

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant Anna E. Yeager

(b) Address 11149 Riverview Blvd.

17. (a) Burial (b) Date thereof Feb. 24 1941

(c) Place: burial or cremation Vahalla Cem.

18. (a) Signature of funeral director Drehmann Harral

(b) Address 1905 Union Blvd.

19. (a) FEB 21 1941 (b) J. B. Breech

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21 year 1941 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb. 18 1941 to Feb. 21 1941 that I last saw him alive on Feb. 20 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 26 days

Due to.....

Due to.....

Other conditions.....

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?.....

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

23. Signature Henry C. Westerman (M. D. or other) M.D.

Address 2136 East Grand Blvd. Date signed 2-21-41

2135 E Street

1-3
7-8

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

A. R. Thompson

Registered Apprentice No.

248

working under my personal supervision.

Signed

R. M. Safford

Licensed Embalmer No.

2233

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34237

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1671

1. PLACE OF DEATH:

(a) County St. Louis Missouri
(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 11149 Riverview Blvd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 11149 Riverview Blvd
(If rural, give location) #. 8
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Theodore Pesger
(b) If veteran, name war _____ (c) Social Security No. _____

20. DATE OF DEATH: Month Jan Day 21
Year 1944 hour _____ minute _____ M.

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace (City, town, or county) _____ (State or foreign country) _____
10. Usual occupation _____

Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name _____
13. Birthplace (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____
15. Birthplace (City, town, or county) _____ (State or foreign country) _____

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? _____

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature Henry C. Westerman (M.D. or other)
Address _____ Date signed _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 7-14-41 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

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

MOTHER FATHER

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

