

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(c) Name of hospital or institution: 424 Cedar 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 31 yrs (Specify whether years, months or days)  
In this community 31 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(d) Street No 2210 So. 6th  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Louis G. Yager

3. (b) If veteran, name war No  
3. (c) Social Security No. 491-10-4421

4. Sex Male 0  
5. Color or race white  
6. (a) Single, married, divorced, widowed Married

6. (b) Name of husband or wife Iowa  
6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Jan 14 1885  
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
57	7	23	hr. min.

9. Birthplace Fort Worth Texas 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business Foundry work

12. Name John Yager

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name unknown  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Wm Yager  
(b) Address St Joseph, MO

17. (a) Burial (b) Date thereof Aug 14, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Auburn Cem.

18. (a) Signature of funeral director Fleming & Son Inc  
(b) Address 1946 Colhoun St Joseph, Mo.  
19. (a) 8-19-42 (b) Rose Heigoy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16th  
year 1942 hour 10 minute 30 P. M.  
viewed

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Concussion with cerebral hemorrhage 1 day deep scalp wound over left eye

Due to Contusion of the chest 1 day

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1860

Major findings: Of operations 39

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) Accident 131

(b) Date of occurrence Aug 16 - 1942

(c) Where did injury occur? St Joseph Buch Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Industrial place foundry  
While at work? yes (Specify type of place) (e) Means of injury Fell from belt

23. Signature H F Mundy (M. D. or other) Carone  
Address 404 So 3d St Date signed 8/17/42

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

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

11  
1  
9

PA. 2

6004

MAR 23 1949  
AUG 1944

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.....  
*Robert H. Gable*

Licensed Embalmer No. 3308

P. O. Address *St Joseph, Mo.*

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.