

FILED MAY 3 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. **158D**

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

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **St Joseph**

(c) Name of hospital or institution: **Mo. Meth. Hosp.**  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **1 hour**  
(If not in hospital or institution, write street number or location)

In this community **59 yrs**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

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

(d) Street No. **2441 Jackson St**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **John F. Yost**

3. (b) If veteran, name war **No**

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **6**  
year **1943** hour **8** minute **P** M.

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Lucille**

6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **Sept 9, 1883**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr 6**, 1943, to **Apr 6**, 1943  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years **59** Months **6** Days **27**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Myocarditis Ch** **Months**

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

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

9. Birthplace **St Joseph Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Tavern owner**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Samuel Yost**

13. Birthplace **St Louis Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Katherine DeFries**

15. Birthplace **St Louis Mo**  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy **Myocarditis Ch**

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

16. (a) Informant **Mrs Lucille Yost**

(b) Address **2441 Jackson St. St Joseph, Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4-9-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt Mora Cem.**

18. (a) Signature of funeral director **FLEEMAN & SON, INC.**

(b) Address **1946 Colhaus St**

19. (a) **4-9-43** (Date received local registrar)

(b) **Rae Hergoy** (Registrar's signature)

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 **L. J. ...** (M. D. or other) **md**

Address **St Joseph, Mo** Date signed **4-8-43**

MAY 4 1954

MAY 21 1954

**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.....

working under my personal supervision.

Registered Apprentice No. ....

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.**