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S. No. 2  
M-9-4-41  
ev-5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

SEP 7 1943 149  
Registration District No. ....

Primary Registration District No. .... 1002

Registrar's No. .... 3734

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.C. TB  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 mo 18 days  
(Specify whether years, months or days)

In this community 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4435 Methers Creek  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Robert Emmett Yeager

3. (b) If veteran, name war. .... 3. (c) Social Security No. none

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married. Divorced Single

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

7. Birth date of deceased November 7 1897  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1943 hour 15.15 minute P M.

21. I hereby certify that I attended the deceased from 9-29-42 to 8-27, 1943 that I last saw h.i. in alive on 8-27, 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 45 Months 9 Days 20 If less than one day hr. min.

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

10. Usual occupation Switchman

11. Industry or business R.R. retired 8 yrs.

12. Name Austin Yeager

13. Birthplace Cedar Rapids Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Cornelia Archer

15. Birthplace Cedar Rapids Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Records K.C. TB Hosp  
(b) Address Reeds Mo.

17. (a) Reeds (b) Date thereof 8-30-43  
(Residence, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence, Kansas

18. (a) Signature of funeral director Thomas Martiny  
(b) Address Kansas City Mo.

19. (a) 8-28-43 (b) D.E. Brown  
(Data received local registrar) (Registrar's signature)

Immediate cause of death Pulmonary Tuberculosis Duration 1 yr.

Due to 13 1/2

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

Major findings: Of operations .....

Of autopsy no

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) .....

23. Signature Matthew J. Homa (M. D. or other) no  
Address Reeds Mo. Date signed 8/27/43

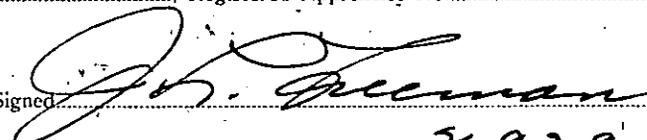
MOTHER FATHER

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

**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. 2939

P. O. Address. K. O. 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.**