

FILED MAR 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7482

State File No. _____

Registration District No. 156

Primary Registration District No. 2.001

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
117 N. Pearl Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Joplin
(If outside city or town limits, write "RURAL")
(d) Street No. 117 N. Pearl Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Hanson Yost

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Margaret Yost 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased August 17, 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 6 11 hr. _____ min.

9. Birthplace Cadis Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Contracting roads

11. Industry or business retired

MOTHER FATHER { 12. Name Wm. J. Yost
13. Birthplace Ind.
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Yost
(b) Address 117 N. Pearl, Joplin, Mo.

17. (a) Burial (b) Date thereof 3-1, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (c) Place: burial or cremation Newtonia Mo. I.O.O.F.

18. (a) Signature of funeral director PARKER-HUNSAKER

(b) Address 1502 Joplin, Joplin, Mo.

19. (a) 3-1-44 (b) Guteub Sudhouth
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 28
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 6, 1944, to Feb. 20, 1944,
that I last saw him alive on Feb. 20, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration _____

Due to Hypertension

Due to Nephritis

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature Dr. E. W. Hergsott (M.D. number) 110

Address 719-20 First Bldg Date signed 3/22/44

44-2-187

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 124

Registration District No. 156

Primary Registration District No. 2001

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Wm Hanson Yeast
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased Aug 17 1904
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 1 (If less than one day) _____ min.

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

10. Usual occupation _____

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)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 28
Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 coronary occlusion Duration _____

Due to Hypertension

Due to Nephritis Chronic

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

Major findings _____
Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1318

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

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

RECEIVED
MAY 10 1964

7482