V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29991

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3725

48
3
8

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: 437 E. GREGORY 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 LIFE TIME
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No. 437 E. GREGORY BLVD 8
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country ---

3. (a) PRINT FULL NAME Miss LELA DEANE YOST

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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 AUGUST 7 1919
(Month) (Day) (Year)

8. AGE: Years 26 Months 0 Days 28 If less than one day ___ hr. ___ min.

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

10. Usual occupation AT HOME

11. Industry or business ----

FATHER
12. Name CHARLES F. YOST
13. Birthplace TOPEKA, KANSAS
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MADDE SWIFT
15. Birthplace KANSAS
(City, town, or county) (State or foreign country)

16. (a) Informant MR. CHARLES F. YOST
(b) Address 437 EAST GREGORY BLVD

17. (a) BURIAL (b) Date thereof SEPT-7-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. N. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 9-7-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 5th
year 1945 hour 3 minute 05 A M.

21. I hereby certify that I attended the deceased from June, 1935 to Sept 5, 1945
that I last saw him alive on in July, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition

Due to Unconscious for over a year

Due to Cerebro spinal disease (Congenital Sues)

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

30 f.

Duration

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) NO
(b) Date of occurrence
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? no (e) Means of injury none

23. Signature Charles C. Dunne (M. D. or other)
Address 1524 PROFESSIONAL BLDG. Date signed 9/5/45

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(Licensed Embalmer's Statement on Reverse Side)

Professional Bldg

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: E. Elsear Worthy

Licensed Embalmer No. 1767

P. O. Address Kansas City.

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.