

No. 2  
5-43  
5-17-39  
I X36671

FILED APR 10 1946

Registration District No. 44 Primary Registration District No. 574-8 4062 Registrar's No. 6

1. PLACE OF DEATH:

(a) County Calderwood

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Calderwood

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nancy Jane Yorkum

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28  
year 1946 hour 6:40 minute A.M.

4. Sex F 5. Color or race Wht

6. (a) Single, widowed, married Divorced Widowed

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

7. Birth date of deceased June 5 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 26, 1946 to Feb 28, 1946  
that I last saw her alive on Feb 28, 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months 8 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic myocarditis

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

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

9. Birthplace Ray County mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions Senile Debility  
(Include pregnancy within 3 months of death)

MOTHER FATHER

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

12. Name Edwin Hendrix

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

14. Maiden name Therese Barber

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

Major findings: Of operations none

Of autopsy none 930

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant P.R. Yorkum

(b) Address Council mo.

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

(c) Place: burial or cremation Council mo

18. (a) Signature of funeral director Cliff Adams

(b) Address Council mo

19. (a) Mar 3/46 (b) Joan Mello  
(Date received local registrar) (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)

(c) Means of injury \_\_\_\_\_

23. Signature Will Johnson (M. D. or other) Dr

Address Council mo Date signed Feb 29 46

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

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**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.....

*Clifford*

Licensed Embalmer No.....

*2194*

P. O. Address.....

*Georgetown 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.**