

FILED JAN 23 1947

Registration District No.

Primary Registration District No. 4097

Registrar's No. 194

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Harrisonville Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
In this community 4 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Laviea Yealey

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive years
7. Birth date of deceased JAN 28 - 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 11 2 hr. min.

9. Birthplace No record (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name No record

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

14. Maiden name No record

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

16. (a) Informant Cass Co. Home records

(b) Address Harrisonville, Mo.

17. (a) Burial (b) Date thereof 12/31/46
(Burial, cremation, or disposal) (Month) (Day) (Year)

(c) Place: burial or disposal Harrisonville, Mo.

18. (a) Signature of funeral director Atkinson

(b) Address Harrisonville Mo.

19. (a) Dec. 30 - 46 (b) Darius Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30
year 1946 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec 10
1946 to Dec 30 1946
that I last saw her alive on Dec 30 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction, refused operation
Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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

22. If death was due to external causes, fill in the following:
(c) 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) Method of injury

23. Signature E. M. Guffey (M. D. or other)

Address Harrisonville Mo Date signed Dec 30 1946

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed ^{Not} ~~by me, or by~~

....., Registered Apprentice No.
working under my personal supervision.

Signed: *Floyd Atkinson*

Licensed Embalmer No. *3920*

P. O. Address: *Harrisonville*

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. Jan 194
Registrar's No. 194

Registration District No. 59

Primary Registration District No. 4097

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(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 _____ years, months or days

3. (a) PRINT FULL NAME

Larissa Yealey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

6. (a) Single, widowed, married divorced wid

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:

Years 78 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county)

(State or foreign country) no record

10. Usual occupation _____

11. Industry or business _____

House wife

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) _____ (Burial, cremation, or removal)

(b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

Bauer J. Jones
(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 _____ 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 _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

PLEASE PRINT—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

39921