

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**13544**

State File No. ....

**FILED APR 29 1949**

No. 300  
10.48

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 133

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).		
a. COUNTY <u>St. Francois</u>			a. STATE <u>Missouri</u>		b. COUNTY <u>St. Charles</u>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		c. LENGTH OF STAY (In this place) <u>2 St. Francois</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Melle</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>			d. STREET ADDRESS (If rural, give location) <u>Unknown</u>		

<b>3. NAME OF DECEASED</b> (Type or Print)			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)		
a. (First) <u>HERBERT</u>	b. (Middle) <u>PHILIP</u>	c. (Last) <u>YAHN</u>	<u>April 5, 1949</u>		

<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Dec. 4, 1879</u>	<b>9. AGE</b> (In years last birthday) <u>69</u>	<b>IF UNDER 1 YEAR</b> (Months) <u>4</u>	<b>IF UNDER 24 HRS.</b> (Days) <u>1</u>	<b>IF UNDER 24 HRS.</b> (Hours) <u>1</u>	<b>IF UNDER 24 HRS.</b> (Min.)
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cottleville, Missouri</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>
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<b>13a. FATHER'S NAME</b> <u>Nicholas Yahn</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Susan Kaiser</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Anna Marie Schneider</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	<b>16. SOCIAL SECURITY NO.</b> <u>489-18-1798</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Records State Hospital No. 4, Farmington, Mo.</u>	<b>ADDRESS</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cerebral Thrombosis</u>		<u>4 days</u>
	<b>ANTECEDENT CAUSES</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Cerebral Arteriosclerosis</u>  DUE TO (c)		<u>years</u> <u>2 1/2 X</u>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <u>Huntington's Chorea</u>		<u>years</u>	

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from** Nov. 9, 1948, to April 5, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

<b>23a. SIGNATURE</b> (Degree or title) <u>John A. Bueman M.D.</u>	<b>23b. ADDRESS</b> <u>State Hospital No. 4, Farmington, Mo. 4-5-49.</u>	<b>23c. DATE SIGNED</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>Apr. 8, 1949</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Weldon Spring Cem.</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>Weldon Spring, Mo.</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>Apr. 15, 1949</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Ether Rudolph</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Muschany Funeral Home, Wentzville, Mo.</u>	<b>ADDRESS</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 4

District Health Officer Number 449-

4-28-

JUL 28 1945

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Paul K. Royal

Licensed Embalmer No. 4420

P. O. Address Laramie Wyo

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.