

FILED SEP 5 1950
#113498THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28826

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2329							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo.				b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO.				c. LENGTH OF STAY (In this place)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL. #1.				STREET ADDRESS (If rural, give location) 2703 N. Union Blvd.									
3. NAME OF DECEASED (Type or Print)			a. (First) OTIS		b. (Middle) YOCUM		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) August 29th, 1950				
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 6 1896		9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Kansas				12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Baker Yocum				13b. MOTHER'S MAIDEN NAME Mary Hayes				14. NAME OF HUSBAND OR WIFE Josephine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#1				16. SOCIAL SECURITY # 494-05-0170		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Yocum 2703 N. Union Blvd							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Esophagus								INTERVAL BETWEEN ONSET AND DEATH			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.											
		DUE TO (b) _____ DUE TO (c) _____											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? 150X							
22. I hereby certify that I attended the deceased from 7/25/50 to 8/29/50, 19, that I last saw the deceased alive on 8/29/50, 19, and that death occurred at 6:10am m., from the causes and on the date stated above.													
23a. SIGNATURE F. J. Calanzano M.D.						23b. ADDRESS 1515 LAFAYETTE AVE.			23c. DATE SIGNED 8/29/50				
24a. BURIAL, CREMATION (REMOVAL) (Specify) Burial		24b. DATE 8/2/50		24c. NAME OF CEMETERY OR CREMATORY				24d. LOCATION (City, town, or county) (State) Seneca Mo.					
DATE RECD BY LOCAL		REGISTRAR'S SIGNATURE J. B. Slaughter				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849 N. Euclid							

(Licensed Embalmer's Statement on Reverse Side)

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

DATE 11/19/50

ms

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 _____

working under my personal supervision.

Student Embalmer No.

Robert L. Drukman

Signed

Signed.....
Student Embalmer

Licensed Embalmer No. *3553*

P. O. Address.....

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.