

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

0020
#

FILED JAN 12 1954

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 3019 Registrar's No. 4

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Andrew</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural</u> ✓ | | c. CITY (If outside corporate limits, write RURAL and give township) <u>002.0</u> <u>0</u> | |
| c. LENGTH OF STAY (in this place) <u>20 yrs</u> | | d. STREET ADDRESS (If rural, give location) <u>4 Miles East of Savannah, Mo.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Andrew County Nursing Home</u> | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Benton</u> c. (Last) <u>Yates</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-4-54</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u> | 8. DATE OF BIRTH <u>Oct 3 1860</u> |
| 9. AGE (In years last birthday) <u>93</u> | | 10. UNDER 1 YEAR Months _____ Days _____ | 11. UNDER 18 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Unknown</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13a. FATHER'S NAME <u>Wm H. Yates</u> | | 13b. MOTHER'S MAIDEN NAME <u>Anna Mary Wells</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Marie Ford, Savannah, Mo.</u> |
| 18. CAUSE OF DEATH 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. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerotic Heart</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senile psychosis</u> <u>10 yrs.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>4200</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from <u>12-29</u> , 19 <u>53</u> to <u>1-4</u> , 19 <u>54</u> that I last saw the deceased alive on <u>12-29</u> , 19 <u>53</u> and that death occurred at <u>9:30 a.m.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>Harvey C. Baker M.D.</u> | | 23b. ADDRESS <u>Savannah, Mo.</u> | 23c. DATE SIGNED <u>1-7-54</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Jan 7 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Whitesville Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Whitesville Mo.</u> |
| DATE REC'D BY LOCAL REG. <u>1-7-54</u> | REGISTRAR'S SIGNATURE <u>William Sparks</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Reid</u> | ADDRESS <u>Savannah, Mo.</u> |

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

STATEMENT BY LICENSED EMBALMER

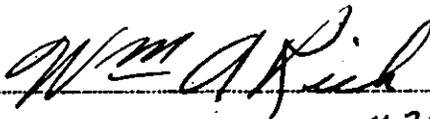
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4228

P. O. Address Savannah, Ga.

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.