

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27865**  
**3751**

FILED AUG 27 1954

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where Decceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>			
b. CITY (If outside corporate limits, write RURAL and give town) <b>KANSAS CITY</b>		c. LENGTH OF STAY (in this place) <b>3 Months</b>		c. CITY OR TOWN <b>WEBB CITY</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>610 NORTH TOM</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>THORNTON</b>		b. (Middle) <b>R.</b>		c. (Last) <b>YOCOM</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>August 1 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced 3</b>	8. DATE OF BIRTH <b>12-30-1900</b>		9. AGE (In years last birthday) <b>53</b>		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) <b>Installation</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roofing &amp; Siding</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Gays, Illinois 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Thornton E. Yocom</b>			13b. MOTHER'S MAIDEN NAME <b>Bernice M. Fleming</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT'S SIGNATURE OR NAME <b>VA Hospital Official Records</b>		ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Obstruction trachea and esophagus</b>				II. OTHER SIGNIFICANT CONDITIONS			<b>1 month</b>
*This does not mean the mode of dying, such as heart failure, asthenia, 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) <b>Metastatic carcinoma to cervical nodes</b>			
				DUE TO (c) <b>Primary squamous cell carcinoma right tonsil</b>			<b>3 months</b>
				<b>Bronchogenic carcinoma, left</b>			<b>2-3 years</b>
19a. DATE OF OPERATION <b>5-10-54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Metastatic squamous cell carcinoma to neck nodas</b>				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) <b>VA</b>		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 <b>April 27, 1954</b> , to <b>August 1, 1954</b> , <del>XXXXXXXXXXXXXXXXXXXX</del> <b>10:50a.m.</b> , and that death occurred at <b>10:50a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Kenneth A. Powell M.D.</b>				23b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		23c. DATE SIGNED <b>8-1-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8-1-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>—</b>		24d. LOCATION (City, town, or county) (State) <b>Webb City, Mo</b>	
DATE REC'D BY LOCAL REG. <b>8-1-54</b>		REGISTRAR'S SIGNATURE <b>Sheraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Johnson-Arma-Simpson, Webb City, Mo</b>			

(Licensed Embalmer's Statement on Reverse Side)

By **Sidmons.**

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 .....  
Signature of Student Embalmer

Signed *John R. Sidmon*

Licensed Embalmer No. 453

P. O. Address *Kansas City*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.