

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17450
STATE FILE NUMBER

FILED JUN 5 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2352

Health, Welfare & Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Hugh H. Owens

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Hickmans Mills Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR O. A. INSTITUTION Menorah Hospital Length of stay in 1b 15 mins.		d. STREET ADDRESS (If outside, give location) 7407 E. 109 Terrace Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle W. Last YOST Jr.			4. DATE OF DEATH Month May Day 20 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 13, 1948
9. AGE (In years last birthday) 9		IF UNDER 1 YEAR Months 9 Days 2 Hours 30 Min. 2	IF UNDER 21 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Burke School	11. BIRTHPLACE (City and state or country) Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Robert W. Yost Sr.	
14. MOTHER'S MAIDEN NAME Patricia Von Achen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hickman, Mills, Mo. Robert W. Yost, Sr., 7407 E. 109 Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fractured skull, fractures of skull multiple abrasions Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) _____			INTERVAL BETWEEN ONSET AND DEATH 29 3/4
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injured in Tornado		20c. TIME OF INJURY Hour 5 Month 5 Day 20 Year 57 a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION COUNTY Jackson STATE MO
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hugh H. Owens Coroner		22b. ADDRESS 1034 Piatto Bldg	22c. DATE SIGNED 5 21 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-23-1957	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 5-21-57	26. REGISTRAR'S SIGNATURE New Marshall

026

KP
2

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 *James W Wair*.....

Licensed Embalmer No. *463*

P. O. Address *K.C., Mo*

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.