Health, & Welfare Public Service

. 300
1-57

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 3822

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 366

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSP. #1. Length of stay in 1b 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN ST. LOUIS Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 1015 S 4th 25 Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last YEAGER
4. DATE OF DEATH Month JAN. Day 8, Year 1958
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-15-1903
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) LABORER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME FRANK YEAGER
13b. MOTHER'S MAIDEN NAME MEDERIA McMANUS
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO. —
17. INFORMANT RALPH YEAGER Address 1015 S. 4th ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Obesity & nephritis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 593x

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/31/57, to 1/8/58 and last saw her/him alive on 1/8/58
Death occurred at 4:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE David S. Johnson M.D. (Degree or Title)
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 1/9/58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 1-14-58
23c. NAME OF CEMETERY OR CREMATORY NATL. CEM
23d. LOCATION (City, town, or county) JEFF BKS (State) MO

24. FUNERAL DIRECTOR EDW FENDLER ADDRESS 5611 S 6
25. DATE RECD. BY LOCAL REG. JAN 13 '58
26. REGISTRAR'S SIGNATURE J Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Not Embalmed

Student ..... Signed Edw. Fender .....

Signature of Student Embalmer

Licensed Embalmer No. .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.