Health, Welfare Public Service

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SL 16437
FILED APR 23 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-016639
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4115

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN 915 N.GRAND,ST.LOUIS, MO. — Inside Limits Yes XX No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET.ADM. HOSPITAL — Length of stay in Hospital 4 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes XX No ☐
d. STREET ADDRESS (If outside, give location) 2328 SUBLETTE AVE. — Reside on Farm Yes ☐ No XX

3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last YOST

4. DATE OF DEATH Month APRIL Day 14 Year 1958

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH 1/14/91

9. AGE (In years last birthday) 67 — 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) MESSENGER-BRINKS INC.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) DUBUQUE, IOWA

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME CASPER YOST

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE LATE MABEL-YOST-

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1

16. SOCIAL SECURITY NO. 494-07-4841A

17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASTASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CARCINOMA OF PYRIFORM SINUS OF THROAT — 6 MONTHS
DUE TO (c) - - - - - -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - - - -

19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐ NONE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 147 X

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/VA attended the deceased from 4/10/58, to 4/14/58 and last saw him alive on 4/14/58
Death occurred at 12:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert C. Donaldson M.D.

22b. ADDRESS VAH, ST. LOUIS, MO.

22c. DATE SIGNED 4/14/58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE APR.16,1958

23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY

23d. LOCATION (City, town, or county) ST. LOUIS CO. (State) MO.

24. FUNERAL DIRECTOR KRIEGSHAUSER ADDRESS 4228 S.KINGSHIGHWAY

25. DATE RECD. BY LOCAL REG. APR 15 '58

26. REGISTRAR'S SIGNATURE Paul Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 William S. White

Licensed Embalmer No. 4291

P. O. Address 4228 So. Kingsley

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.