

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034946

STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2381

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>White</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>8120 Carmi</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		Length of stay in 1b <u>1 day</u>	8 STREET ADDRESS (If outside, give location) <u>8</u>
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>E.</u> Last <u>Yates</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>58</u>	

5. SEX <u>Male</u> <u>0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1900</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
--------------------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Male Nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Carmi, Illinois.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	---

13a. FATHER'S NAME <u>Silas Yates</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Huff</u>	14. NAME OF HUSBAND OR WIFE <u>UNK.</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> <u>Nil.</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Doris Adams, Carmi, Illinois.</u>	Address
---	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular collapse</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Retroperitoneal hemorrhage (post-operative)</u>	
	DUE TO (c) <u>Sympathectomy (operative) for femoral embolus</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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.)
---	--

20c. TIME OF INJURY Hour <u>1:20</u> Month, Day, Year <u>a.m.</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Carmi</u>	COUNTY <u>White</u>	STATE
--	--	--	--	------------------------	-------

21. I attended the deceased from <u>9-12-58</u> to <u>9-13-58</u> and last saw ^{him} <u>him</u> alive on <u>9-13-58</u> Death occurred at <u>1:20 a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John E. Oakley, M.D.</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>9/13/58</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-13-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	23d. LOCATION (City, town, or county) <u>Carmi, Illinois.</u>	(State)
---	-----------------------------	--	--	---------

24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>9-15-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert P. Rombe M.D.</u>
--	--	--	---

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 *Etton H. Penelhas*

Licensed Embalmer No. *4283*

P. O. Address *St. Louis 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.