

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-044917
STATE FILE NUMBER

FILED DEC 18 1958

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 409

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</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>Residence 908 Georgia</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>908 Georgia</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE HUFFMAN YARGUS</u>			4. DATE OF DEATH Month Day Year <u>December 6, 1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1867</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Fulton County Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13a. FATHER'S NAME <u>J. F. Huffman</u>		13b. MOTHER'S MAIDEN NAME <u>Patricia Cooper</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel Yargus (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Hazel Beal, Hannibal, Mo</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>Coronary infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterior sclerosis generalized with complete left hemiplegia</u>					Two years
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 <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	
21. I attended the deceased from <u>Sept 4, 1958</u> to <u>Dec 6, 1958</u> and last saw her alive on <u>Dec 6, 1958</u> Death occurred at <u>2:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>M. D. 707 Bdwy, Hannibal, Missouri</u>		22c. DATE SIGNED <u>12-8-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/9/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>W. Crawford Smith, Hannibal Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>12-10-58</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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
MEDICAL CERTIFICATION

RECEIVED DEC 16 1958

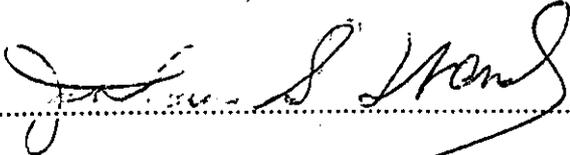
MARION CO. HEALTH DEPT.

DATE FILED DEC 16 1958

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 

Licensed Embalmer No. 4500.....
P. O. Address Hannibal Missouri

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.