

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011981

STATE FILE NUMBER

FILED APR 3 1959

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 53

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sikeston,</u> <u>100.3</u> <u>0</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>226 Felker St.</u>		Length of stay in lb <u>37yr.</u>	d. STREET ADDRESS (If outside, give location) <u>226 Felker</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>XXXXXX</u> Last <u>Yarber</u>			4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1959</u>			
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5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negrc</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>February 23, 18</u>	9. AGE (In years (As birthday) <u>69</u>)	IF UNDER 1 YEAR Months <u>0</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pool Hall</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>	11. BIRTHPLACE (City and state or country) <u>Oxford, Miss.,</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Will Yarber</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lattie Yarber</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Lattie Yarber</u>	Address <u>220 Felker St</u>
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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>Gun Shot Wound, In Left Chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
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)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Self Inflected</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month _____ Day _____ Year _____
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20d. INJURY OCCURRED WHILE AT <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.) <u>In Home</u>	20f. CITY, TOWN, OR LOCATION <u>Sikeston</u>	COUNTY <u>Scott</u>	STATE <u>Mo.</u>
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21. I attended the deceased from First call after death and last saw ^{her}him alive on _____
Death occurred _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Lyde Pol</u> (Degree or title) <u>3</u> <u>(Coroner)</u>	22b. ADDRESS <u>Sikeston Mo.</u>	22c. DATE SIGNED <u>4/23/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-26-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smith W. End Cant West of Sikeston, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>West of Sikeston, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. J. Smith</u>	ADDRESS <u>1212 Main</u>	25. DATE RECD. BY LOCAL REG. <u>3-26-59</u>	26. REGISTRAR'S SIGNATURE <u>W. C. Hunter</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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

Fred J. Smith

Licensed Embalmer No. *4408*

P. O. Address *Sikeston, 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.