

FEDERAL BUREAU OF INVESTIGATION
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020774

STATE FILE NUMBER

JUL 13 1959 77

Primary Registration District No. 3016

Registrar's No. 198

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MORGAN</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>JEFFERSON-CITY</u>		Length of stay in 1b <u>16 days</u>		c. CITY OR TOWN <u>BARNETT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST-MARYS-HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>BARNETT</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose-</u> Middle <u>Lee</u> Last <u>Yows</u>				4. DATE OF DEATH Month <u>JUNE-</u> Day <u>29</u> Year <u>1959</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>21 Nov-1899</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At-Home</u>		11. BIRTHPLACE (City and state or country) <u>MORGAN-Co-Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>ISAAC-Imler-</u>			13b. MOTHER'S MAIDEN NAME <u>MARY-J-SULLIVAN-</u>			14. NAME OF HUSBAND OR WIFE <u>NORMAN-Yows</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>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CARL-Yows - New Bloomfield-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>Cerebral hemorrhage</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</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) <u>neuroarterial sclerosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
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.) <u>NONE</u>						
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____ <u>NONE</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.) <u>NONE</u>		20f. CITY, TOWN, OR LOCATION <u>NONE</u>		COUNTY		STATE	
21. I attended the deceased from <u>June 12</u> to <u>June 29</u> and last saw her <u>alive</u> on <u>June 29/59</u> Death occurred at <u>1:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Wm G Daylan M.D.</u>					22b. ADDRESS <u>JEFFERSON-CITY - Mo</u>			22c. DATE SIGNED <u>30 June-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1 July 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Big-Rock-</u>		23d. LOCATION (City, town, or county) <u>MORGAN-Co-Mo</u>					
24. FUNERAL DIRECTOR <u>Keith M Kays</u>			ADDRESS <u>ELDON-Mo</u>		25. DATE RECD. BY LOCAL REG. <u>30 June 1959</u>		26. REGISTRARS SIGNATURE <u>R.P. Davis, MA-MR</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Keith McKay

Licensed Embalmer No. 3998

P. O. Address Eldon 70

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.