

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022576

FILED JUL 1 1959 9/14

Registration District No. 9/14 Primary Registration District No. 4439 Registrar's No. 35 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Clair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Length of stay in 1b <u>3 Month</u>	c. CITY OR TOWN <u>Collins</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>Knight's Store *</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>James</u> Middle <u>Clyde</u> Last <u>Yost</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</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>Sept: 12, 1884</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer *</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator *</u>	11. BIRTHPLACE (City and state or country) <u>Polk County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>James W. Yost</u>		13b. MOTHER'S MAIDEN NAME <u>Olive Morgan</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased *</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>489-46-5587</u>	17. INFORMANT Address <u>Albert Peden, Collins Missouri</u>			
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>Myocardial Infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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	COUNTY	STATE	
21. I attended the deceased from <u>April 3, 1959</u> to <u>June 22, 59</u> and last saw him alive on <u>June 22, 1959</u> Death occurred at <u>10:A.M</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Herbert M. Mason M.D.</u>			22b. ADDRESS <u>Osceola Missouri</u>		22c. DATE SIGNED <u>6/25/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holsapple</u>	23d. LOCATION (City, town, or county) (State) <u>Collins Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Goodrich Funeral Home, Osceola Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Paul Sweeney</u>			

DOCUMENT

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed FB Paswick

Licensed Embalmer No. 303

P. O. Address Oscoda

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
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.