

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028113

FILED VS SEP 14 1959

Registration District No. 30 Primary Registration District No. 4038 Registrar's No. 33

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>BENTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>BENTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WARSAW, Mo</u>		c. CITY OR TOWN <u>WARSAW,</u>	
Length of stay in lb <u>Life</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>None</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL ELMER YEAGER</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 3, 1959</u>		
5. SEX <u>Male</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>APR. 9, 1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>4 24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>Edmondson, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Daniel W. Yeager</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Noel</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Yeager</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>Mrs Emma Yeager, Warsaw Mo</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Congestive Circulatory Failure</u>		<u>1 day</u>
Thrombotic Encephalomalacia and prolonged Recumbency 2 yrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	<u>Arteriosclerosis</u>	<u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour a.m. p.m. <u>None</u>	Month, Day, Year <u>None</u>
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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>Warsaw, Mo.</u>	COUNTY <u>Benton</u>	STATE <u>Mo</u>
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21. I attended the deceased from Jan., 10, 1949, to Sept., 3, 1959 and last saw her/him alive on Sept 2, 1959
Death occurred at 10:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Lawrence D. D</u> (Degree or title)	22b. ADDRESS <u>Warsaw, Mo.</u>	22c. DATE SIGNED <u>9-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Camp Ground</u>	23d. LOCATION (City, town, or county) (State) <u>Edwards Benton Co. Mo</u>
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24. FUNERAL DIRECTOR <u>John J. Reese</u> ADDRESS <u>Warsaw</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 6, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Gas. A. Logan</u>
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(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 John F. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.