

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029874

FILED VS SEP 4 1959

Registration District No. _____ Primary Registration District No. **239** Registrar's No. **4356** STATE FILE NUMBER **15**

1. PLACE OF DEATH a. COUNTY New Madrid				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY New Madrid					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Parma		Length of stay in 1b 2 mos.		c. CITY OR TOWN Parma		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			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 type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Phillip Edgar Yocum				4. DATE OF DEATH Month Day Year Aug, 7, 1959.					
5. SEX M	6. COLOR OR RACE cauc.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1894	9. AGE (last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) State of Illinois		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Lafferty Yocum			13b. MOTHER'S MAIDEN NAME Ida Mae McClur		14. NAME OF HUSBAND OR WIFE Flossie Yocum				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 496-40-0484		17. INFORMANT Address Flossie Yocum Parma, Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia							INTERVAL BETWEEN ONSET AND DEATH 2 days		
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)					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 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 12:30 A.M. to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Hayne Coan M.D.</i>				22b. ADDRESS <i>Malden Mo.</i>		22c. DATE SIGNED 8-11-59			
23a. BURIAL, CREMATION, OR MOVING (Specify) Burial		23b. DATE Aug. 9, 1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Malden Missouri				
24. FUNERAL DIRECTOR ADDRESS <i>Watkins Funeral Service Parma Mo.</i>				25. DATE RECD. BY LOCAL REG. 8/15/59		REGISTRAR'S SIGNATURE <i>Dr. Hesh. Husted, M.D.</i>			

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marsh Watkins

Licensed Embalmer No. 4713
P. O. Address Deister

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.