

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013442

FILED VS MAR 3 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 3329** STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b 42 days	c. CITY OR TOWN E. St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2601 Tudor Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JACK YARBOUGH, Sr.			4. DATE OF DEATH Month MARCH Day 20 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 3 Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY ELKS CLUB	11. BIRTHPLACE (City and state or country) Jackson, Tennessee		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Lewis Yarbough		13b. MOTHER'S MAIDEN NAME Lucille Hunter		14. NAME OF HUSBAND OR WIFE Lillie B. Yarbough	

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. 329-12-3801	17. INFORMANT Lillie Yarbough	Address 2601 Tudor
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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) Metastatic Carcinoma Brain		3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma Left Lung	9 months
	DUE TO (c) 163x	

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
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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 checked="" 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 **10/30/59** to **3/20/60** and last saw him alive on **3/20/60**
Death occurred at **11:30A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE F R Bradley (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/20/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-29-60	23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens	23d. LOCATION (City, town, or county) (State) East St. Louis, Illinois
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24. FUNERAL DIRECTOR NASH FUNERAL HOME ADDRESS M. J. Nash 111 N. 13th	25. DATE RECD. BY LOCAL REG. MAR 23 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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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 *M. Francis*
Licensed Embalmer No. 445

P. O. Address 117. 13

STATEMENT BY LICENSED EMBALMER

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.