RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-013444

FILED VS APR 4 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2548 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 62 Yrs.	c. CITY OR TOWN St. Louis County — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Stone Nu rsing Home — Inside Limits Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location) 10201 W. Florissant — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Emma	Middle	Last Yost	4. DATE OF DEATH Month March	Day 3,	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐	8. DATE OF BIRTH 8-13-1876	9. AGE (last birthday) 83	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) At Home	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Herman, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Anton Nebel	13b. MOTHER'S MAIDEN NAME Rosa Hatt		14. NAME OF HUSBAND OR WIFE Frank P. Yost		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Cecelia Schroeder	Address 10201 W.Florissant	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

O.K. Joseph M. Lucas Deputy Dir. 3-6

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	30 minutes
DUE TO (b)	CORONARY THROMBOSIS	
DUE TO (c)	CORONARY ARTERIOSCLEROSIS	YEARS

Conditions, if any, which give rise to above cause (a) stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Chronic Brain Syndrome General Arteriosclerosis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.1

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 3-2-60 to 3-3-60 and last saw her/him alive on 3-2-60

Death occurred at 3-3-60 9.25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert J. Peterson M.D.	22b. ADDRESS 4375 W. Pine	22c. DATE SIGNED 3-4-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-7-1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. MAR 4 1960	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis [illegible]

Licensed Embalmer No. 3563

P. O. Address 3840 [illegible]

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