

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-041872

STATE FILE NUMBER

AMENDED

Primary Registration District No. 231 Registrar's No. 289

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>NODAWAY</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARYVILLE</u>		Length of stay in lb <u>8 mos.</u>	c. CITY OR TOWN <u>CONCEPTION Jct.</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>NODAWAY NURSING HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" 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 (Type or print) First Middle Last <u>WILLIAM VAN YEARY</u>			4. DATE OF DEATH Month Day Year <u>NOV. 26, 1961</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>5-25-1873</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
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>RETIRED</u>	11. BIRTHPLACE (City and state or country) <u>LEE Co. VIRGINIA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>JOHN YEARY</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH ZION</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. ROSA YEARY</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>UNKNOWN</u>		17. INFORMANT Address <u>MRS. ROSA YEARY - CONCEPTION Jct.</u>	

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 <u>sudden several year</u>
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			
DUE TO (b) <u>Generalized Arteriosclerosis</u>			
DUE TO (c) <u>Senility</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.)	
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 Dec 22, 1960 to Nov. 26, 1961 and last saw her alive on Nov. 15, 1961
Death occurred at 6:40 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.R. Jackson, M.D.</u> (Degree or title)		22b. ADDRESS <u>Maryville, Mo.</u>		22c. DATE SIGNED <u>12-1-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV 28-1961</u>	23c. NAME OF CEMETERY <u>OAK LAWN</u>	23d. LOCATION (City, town, or county) (State) <u>RAVENWOOD, MO.</u>	

24. FUNERAL DIRECTOR <u>Stanberry, Mo.</u> <u>Rev. E. Johnson - Funeral Homes</u>	25. DATE RECD. BY LOCAL REG. <u>12-4 61</u>	26. REGISTRAR'S SIGNATURE <u>Bevo Holt</u>
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DATE REVIEWED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Lois Emma Johnson

Licensed Embalmer No. 4948

P. O. Address Stanberry

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.