

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0016353

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 3 1965

Registration District No. 3046

Primary Registration District No. 3042

Registrar's No. 109407

VS 300
Rev. 4/59

1 0621

2 0945

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12 1-0

13 3.0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Madison			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Francois		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fredericktown		Length of stay in 1b 2 Days	c. CITY OR TOWN Farmington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Madison Memorial			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 212 N. Franklin St.	
3. NAME OF DECEASED (Type or print) Chalmer Glenwood Yates			4. DATE OF DEATH Month April Day 16 Year 1965		
5. SEX Male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/20/13	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Electrician	11. BIRTHPLACE (City and state or country) Esther Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Yates		13b. MOTHER'S MAIDEN NAME Octavia unknown		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War #2			17. INFORMANT Address Octavia Yates Farmington, Mo.		
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) Bronchopneumonia					2 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Staphylococcus suspected					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cardiac Failure				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 checked="" 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 <u>4-14-65</u> to <u>4-16-65</u> and last saw her/him/alive on <u>4-16-65</u> Death occurred at <u>115</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE T. Buchanan MD (Degree or title)			22b. ADDRESS Farmington Mo.		22c. DATE SIGNED 4-16-65
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/65	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Leadington, Mo.
24. FUNERAL DIRECTOR C.H. Cozean Farmington, Mo. ADDRESS			25. DATE RECD. BY LOCAL REG. APRIL 17, 1965	26. REGISTRAR'S SIGNATURE Charles Croomey	

USE BLACK INK OR TYPEWRITER RIBBON

X

1965

MAY 6 1965

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 C. McCreary

Licensed Embalmer No. 4084

P. O. Address Farmington, Mo.

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.