DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6239

FILED MAR 3 1943 129

Registration District No. 129 Primary Registration District No. 5180 Registrar's No. 3

1. PLACE OF DEATH:

(a) County: Cape Girardeau

(b) ~~City or~~ town: Neely's Landing (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community: All of life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Cape Girardeau

(c) ~~City or~~ town: Neely's Landing (If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: ROBERT THEODORE YANCEY

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Jessie McClard

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Aug 10 - 1867 (Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace: Neely's Landing (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: .....

FATHER
12. Name: William C Yancey
13. Birthplace: Neely's Landing (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Martha Abernathy
15. Birthplace: Neely's Landing (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature: Mattie M. Nunes

(b) Address: Neely's Landing, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-18-42 (Month) (Day) (Year)

(c) Place: burial or cremation: Applecreek Cemetery

18. (a) Signature of funeral director: A. Miller

(b) Address: Jackson Mo

19. (a) 1-18-42 (Date received local registrar) (b) F. J. Schoen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16th year 1942 hour ..... minute ..... A. M.

21. I hereby certify that I attended the deceased from Jan 12th, 1942 to Jan 16th, 1942; that I last saw him alive on Jan 16, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastro-intestinal hemorrhage	4½ days
Due to Ulcer	
Due to	
Other conditions (Include pregnancy within 3 months of death): Mitral regurgitation	?

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature: G. B. Schulz (M. D. ~~coroner~~)

Address: Cape Girardeau, Mo. Date signed 1/17/42

124 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

RECEIVED
District Health Officer No. 4
District File Number 242-248
Date Filed 2-12-42

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 Gene C. Crawford, Registered Apprentice No. 300, working under my personal supervision.

Signed Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Jackson 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 this body is not embalmed, above space should be left blank.

.2B
9-21-41
.29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6239

Registration District No. 129 Primary Registration District No. 5180 Registrar's No.

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Nellis Landing
(If outside city or town limits, write "RURAL" and name township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Robert T. Yancey
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Aug (Month) 10 (Day) 1867 (Year)

8. AGE: Years 74 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Gastro-intestinal Hemorrhage.	3 days
Due to: ulcer of stomach. Had an attack 7 years previously.	6 mos
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: Refused	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

117a