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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14106

Registration District No. 167 Primary Registration District No. 3040 Registrar's No. 54

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chillicothe Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or ~~institution~~ 2 weeks, (Specify whether years, months or days)
In this community All His Life

2. USUAL RESIDENCE OF DECEASED: 59
(a) State Missouri (b) County Livingston
(c) City or town Dawn
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles Albert YOUMANS
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elizabeth T.
6. (c) Age of ~~husband or~~ wife if alive 75 years
7. Birth date of deceased June (Month) 22 (Day) 1869 (Year)

8. AGE: Years 77 | Months 9 | Days 18 | If less than one day hr. min.

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

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

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

16. (a) Informant Elizabeth YOUMANS
(b) Address Chillicothe, MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation Enon Cemetery
18. (a) Signature of funeral director E. A. Dennison
(b) Address Bogard, MO.
19. (a) April 11 47 (Date received local registrar) (b) Flavera B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 10 year 1947 hour 11 a. minute 00 a. M.
21. I hereby certify that I attended the deceased from 4-26-46, 19, to 4/10/47, 1947; that I last saw him alive on 4/10/47, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chr. Myocarditis	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
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? (Specify type of place)
While at work (e) Means of injury 0
23. Signature D. M. Dowell (M. D. or other)
Address Chillicothe MO Date signed 4/11/47

171 (Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed E. A. Dickerson

Licensed Embalmer No. 2534

P. O. Address Bogard 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, fact should be so stated above.