U. S. No. 2
0M—5-43
ev. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16569

Registration District No. 5-3 Primary Registration District No. 3011 Registrar's No. 48

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Staton Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether)
In this community
years, months or days)

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

3. (a) PRINT FULL NAME: Jesse E Youmans
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rosa Youmans
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 (Month) 26 (Day) 1873 (Year)

8. AGE: Years 71 Months 2 Days 18 If less than one day hr. min.

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

MOTHER FATHER
12. Name Albert Youmans
13. Birthplace Mo (City, town, or county) Mo (State or foreign country)
14. Maiden name Sarah Hull
15. Birthplace Mo (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Roy Dson
(b) Address Bogard Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Ebenezer
18. (a) Signature of funeral director E. A. Dickerson
(b) Address Bogard Mo
19. (a) (Date received local registrar) (b) Mrs James Raffety (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1945 hour 10 minute 35 P.M.
21. I hereby certify that I attended the deceased from May 7, 1942 to May 13, 1945; that I last saw him alive on May 13, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Angina Pectoris	6 da
Due to: Coronary occlusion	
Due to: Old clot	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 140
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

23. Signature R. Hamilton Stuton (M. D. or Coroner) MD
Address Carrollton, Mo. Date signed May 8, 1945

1025

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 6/8/45

FEB SEP DEC 52

JUL 27 1945

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 Boyd 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.