

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.

REG'D AUG 14 1939 3
Registration District No. _____

Primary Registration District No. 6018A

Registrar's No. 118

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Delassus St. Francois
(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 _____)

In this community _____
years, months or days _____

3. (a) PRINT FULL NAME William Henry Yancey

3. (b) If veteran, name war _____

3. (c) Social Security No. 495-14-2887

4. Sex M.

5. Color or race W.

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

6. (b) Name of husband or wife Sarah Willey

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

7. Birth date of deceased April 8 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace Doe Run Mo
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Peter Yancey

18. Birthplace Old Country Germany?
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Lattie Kimmel

15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Firmin Yancey

(b) Address Farmington Mo.

17. (a) Doe Run Mo (b) Date thereof July 22 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Doe Run Mo.

18. (a) Signature of funeral director C. Hugo Cozart

(b) Address Farmington Mo.

19. (a) July 21-39 (b) B. J. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Delassus
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1939 hour 7 AM minute 05 M.

21. I hereby certify that I attended the deceased from June 16
_____, 1939, to July 14, 1939;
that I last saw him alive on July 14, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. L. Watkins (M. D. or other) _____

Address Farmington Mo Date signed 7-21-39

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed C. H. Otzean
Licensed Embalmer No. 40 84
P. O. Address Farmington M.

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.