

FILED MAR 27 1944

Primary Registration District No. 1003

Registrar's No. 2496

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Melbourne Hotel 3360 Lindell
(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 John Edward Yoest

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Cornelia Yoest

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Dec. 8 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

42	3	5	_____ hr. _____ min.
----	---	---	----------------------

9. Birthplace California Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business _____

MOTHER FATHER

12. Name John Yoest

13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Mary Wahle

15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Cornelia Yoest

(b) Address St. Charles, Mo.

17. (a) Burial (b) Date thereof 3-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) J. F. Brueck
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 92

(c) City or town St. Charles
(If outside city or town limits, write "RURAL") NR

(d) Street No. 803 N. 4th St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1944 hour 3:50 minute 9 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.

Immediate cause of death _____

Chronic Hypertrophic

Due to Endocarditis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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)

23. Signature W. J. Perry (M. D. or other) _____
Address St. Charles, Mo. Date signed 3/14/44

JUN 3 1955

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 *G. W. Wilkinson*
Licensed Embalmer No. 3575

P. O. Address.....

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.