

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 recorded. A request for a full and complete statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Pettis

Township _____

Registration District No. 668

File No. 5656

Village _____

Primary Registration District No. 3632

Registered No. 35

City Sedalia

(NO. 409-E-15)

St. 34 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Adalina Margaret Younker

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH October 13, 1897 (Month, Day, Year)

AGE 33 years 3 months 24 days

OCCUPATION (a) Trade, profession, or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) High School

BIRTHPLACE—(City or town, State or foreign country) Missouri

NAME OF FATHER George Younker

BIRTHPLACE OF FATHER (City or town, State or foreign country) Illinois

MAIDEN NAME OF MOTHER Margaret Kirtz

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Younker

(ADDRESS) Sedalia, Mo.

Filed Feb 7 1914 A. B. P. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 6, 1914 SEX Female COLOR OR RACE White (Month, Day, Year)

I HEREBY CERTIFY, that I attended deceased, from Jan 4, 1914, to Jan 6, 1914, that I last saw him alive on Jan 6, 1914, and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Septicemia

Contributory (SECONDARY) Septicemia of Heart

(Address) Sedalia, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Lake Creek Cemetery

DATE OF BURIAL Feb 8 1914

UNDERTAKER McLaughlin Bros. ADDRESS Sedalia Mo.

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.

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____ St. _____ Ward _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)	DATE OF BIRTH	
			(Month) _____, 191____ (Day) _____ (Year) _____	AGE
			_____ yrs. _____ mos. _____ ds.	If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____				

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS