

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

Do not use this space.

15749

1. PLACE OF DEATH

County Marion
Township Liberty
City Palmyra

Registration District No. 5-48
Primary Registration District No. 432B

File No. _____
Registered No. 19 St. _____ Ward _____

2. FULL NAME

H. Clay Young
(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mollie Paynter</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan. 25 - 1842</u>		
7. AGE	YEARS <u>85</u>	MONTHS <u>4</u>
	DAYS <u>6</u>	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work W. farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Marion County Mo
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>John R. Young</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Lucinda Burgh</u> ^{5/2}
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)

14. INFORMANT Miss D. ene Young
(Address) Palmyra Mo

15. FILED 5/2 1927
L. Sanford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st 1927
17. I HEREBY CERTIFY That I attended deceased from April 10 1927, to May 1st 1927 that I last saw him alive on Apr 27 1927, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess of brain

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH? _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) C. W. Harlin, M. D.
Palmyra Mo 1927 (Address)

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH? _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) C. W. Harlin, M. D.
Palmyra Mo 1927 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

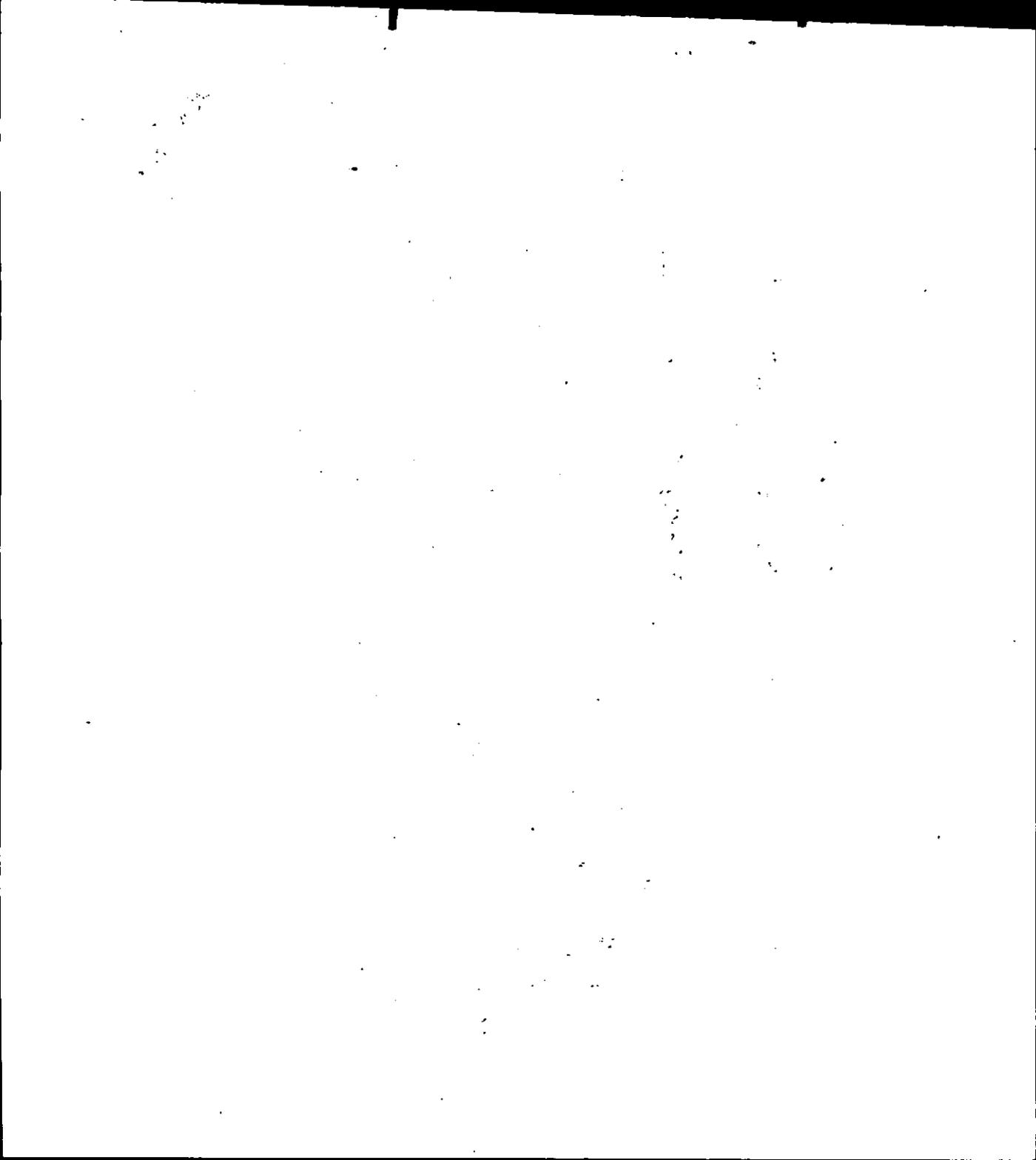
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood DATE OF BURIAL May 3 1927

20. UNDERTAKER A. W. Sprague ADDRESS Palmyra 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.

THIS IS A PERMANENT RECORD

28 1927



Was the abscess tuberculous or due to other infection or traumatic? If traumatic please state kind of accident. Please sign and return.

Not Traumatic. Cause not known.

7-14-'27

S. Sanford
L.R.

64651-S

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 548 File No.
 Township Palmers Primary Registration District No. 4328 Registered No. 19
 City (No.) St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 19 19 J. Sanford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May, 1927

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Phases of heart
 (duration) yrs. mos. ds. 700
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15749