

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

Do not use this space.

36945

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City Kansas City (No. 1228 1/2 Campbell)

File No. _____
 Registered No. 4768
 St. _____ Ward _____

2. FULL NAME

Frank Young
 (a) Residence. No. 1228 1/2 Campbell St. Ward 1
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-4-1859

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	68	2	17	

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

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

10. NAME OF FATHER W.H. Farrow

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

12. MAIDEN NAME OF MOTHER May Hick

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

14. INFORMANT Mrs. R.M. Carter
 (Address) 1228 1/2 Campbell

15. FILED 12-17-27 M.M. Crowe
 Ass't REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1927 to Dec 16 1927, and that I last saw him alive on Dec 15 1927, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

angina pectoris
Do not know (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) pract otitis
schison (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Do not know
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH Do not know DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Edward Long, M.D.
Dec 16 1927 (Address) 520 Commercial

*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 Delphos Kansas DATE OF BURIAL Dec 17 1927

20. UNDERTAKER Mrs. E. L. Foster ADDRESS K. C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

520 Commerce Bldg.

m. 5-278 .

2:30 to 5.