

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

Do not use this space.

24 1929

9827

1. PLACE OF DEATH

County Cape Girardeau, Mo. Registration District No. 125
Township Cape Girardeau, Mo. Primary Registration District No. 3009
City Cape Girardeau, Mo.

File No. 9827
Registered No. 75
St. _____ Ward _____

2. FULL NAME

Mrs. Connie Dell Young

(a) Residence No. R.O. Dist. 1, No. 1, Springfield, Mo. Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 7 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 21, 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>35</u>	<u>9</u>	<u>1</u>	<u>23</u>	<u>24</u>

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 189 C 129 E 26
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cape County, Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER John Strong

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cape County, Missouri
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rachael De Vore

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cape County, Missouri
(STATE OR COUNTRY)

14. INFORMANT Mr. C. L. Young
(Address) Red Star, R.O. #1

15. FILED 3/16, 1929 W. O. Staempfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14, 1929

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to Mar 14, 1929, that I last saw alive on March 13, 1929, and that death occurred, on the date stated above, at 4:10 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
General debility, following stroke & repair of heart

CONTRIBUTORY (SECONDARY) Strain & Typhoid infection
(duration) 1 yrs. 1 mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED Cape Girardeau, Mo.
IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-8-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physician & Clinical

(Signed) W. O. Staempfer, M. D.
3-15-29 (Address) Cape Girardeau

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairmont DATE OF BURIAL March 16, 1929

20. UNDERTAKER W. O. Staempfer ADDRESS 536 Parkway

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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Envelope



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

9821
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape Gir. Registration District No. 125- File No.
Township Primary Registration District No. 3009 Registered No. 75-
City (No.) St. Ward)

2. FULL NAME Mrs. Connie Dell 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-21-1891

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
37 11 23

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 5/18 29 W. Kauffman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 14 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia following
uterine & vaginal
infection
(duration) yrs. mos. ds. X
CONTRIBUTORY (SECONDARY) uterine & vaginal
infection (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Was not a purpural
IF NOT AT PLACE OF DEATH, infection
DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Dr. [Signature] M. D.
(Signed) 5-17 1929 (Address) W. Kauffman

*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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. N. B.—Every item of information should be carefully supplied. Every item of information should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

5-9827