

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

Do not use this space.

14266

1. PLACE OF DEATH

County Jackson Registration District No. 395
 Township Raw Primary Registration District No. 1002
 City N. C. Mo. (No. 2300, Judg. Ave.) St. _____ Ward _____

File No. _____
 Registered No. 1782

2. FULL NAME

Angie Young
 (a) Residence. No. 2300 Judg. Ave. St. 9 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 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 Wm Young

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-19-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
69 5 6

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) 295
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas 21

10. NAME OF FATHER Gas. Cooley

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

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record 31

14. INFORMANT Duff Young
 (Address) 2306 Judg. Avenue

15. FILED 4/16, 1931 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April-15 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
93°
97 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 93°

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Hayes, M. D.
4/15, 1931 (Address) Deputy Coroner

*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 Eflingham, Mo. DATE OF BURIAL 4-17 1931

20. UNDERTAKER Mrs. C. L. Foster ADDRESS N. 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.

