

SEP 15 1939

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

30375
Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 838
(b) Township Salt River Primary Registration District No. 6071 Registered No. 37
(c) City Shelbina (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jennie Pearl Young

(a) Residence, No. 524 Shelby Co. Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 Geo. W. Young

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/4/1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
67 5 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as housekeeper
9. Industry or business in which work was done, as housekeeper
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Decatur City
(STATE OR COUNTRY) Iowa

FATHER 13. NAME Henry C. Wells

14. BIRTHPLACE (CITY OR TOWN) Gentry Co.
(STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Sarah Covington

16. BIRTHPLACE (CITY OR TOWN) Quincy
(STATE OR COUNTRY) Illinois

17. INFORMANT Geo. W. Young
(ADDRESS) Shelbyville Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grand River Ia. DATE 8/20/39

19. FUNERAL DIRECTOR (NAME) Million & Barkelew
(ADDRESS) Shelbina Mo.

20. FILED Aug 18 19 39 Ruth Jayner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 14 1939, to Aug 16, 1939
I last saw her alive on Aug 16, 1939. Death is said to have occurred on the date stated above, at 11:05 a.m.
The principal cause of death and related causes of importance were as follows:

Septicemia Date of onset Aug 10 39

Other contributory causes of importance: Infection from Paratyphoid Aug 10 -

Name of operation Paratyphoid Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify. S. L. Simpson M.D.
(Signed) Shelbina Mo.
(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.

PE

RECEIVED.

District Health Officer No. 10

District File Number Q-39-1608

Date Filed SEP 11 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signature Wm E. McLean

Licensed Embalmer No. 3957

P. O. Address Shelburne Vno.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30375-7
Do not use this space.

1. PLACE OF DEATH
 (a) County Shelby Registration District No. 830
 (b) Township Salt River Primary Registration District No. 609.1 Registered No. 37
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jennie Pearl Young
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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.
	<u>67</u>	<u>5</u>	<u>12</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____
 Local Registrar _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____.

The principal cause of death and related causes of importance were as follows:
Septicemia
#77, M. R. # 130
 Date of onset

Other contributory causes of importance:
Infection from Paraneplhrinosis # N. M. R. II

Name of operative Paraneplhrinosis Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) S. L. Simpson, M.D.
 (Address) Shelby, Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

S-30375