

REC'D OCT 18 1940

Registration District No. **377**

Primary Registration District No. **3079**

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal, Mo.**
(c) Name of hospital or institution: **St. Elizabeth Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **25 days.**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **William Young**

3. (b) If veteran, name war *********
3. (c) Social Security No. **497-09-2881**

4. Sex **male** 5. Color or race **colored** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife ********* 6. (c) Age of husband or wife if alive ********* years

7. Birth date of deceased **Sep. 19 1908**
(Month) (Day) (Year)

8. AGE: Years **32** Months **11** Days **17**
If less than one day
..hr. ..min.

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer.**

11. Industry or business **Gen. Labor.**

12. Name **Walter Young**

13. Birthplace **Palmyra Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Katie Julius**

15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Katie Buckner**

(b) Address **Palmyra, Mo.**

17. (a) **Removal & Burial** (b) Date thereof **Sep. 4 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Palmyra Mo.**

18. (a) Signature of funeral director **E. S. Spangue**

(b) Address **Palmyra, Mo.**

19. (a) **9-10-40** (b) **M. C. Fisher**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Marion**
(c) City or town **Palmyra**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept 2 - 40** day
year _____ hour **5** minute _____ A.M.

21. I hereby certify that I attended the deceased from **Aug - 7 - 40**
_____ 19____ to **Sept 2 - 40** 19____

that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Lung abscess**
Duration **2 weeks**

Due to **auto injury - fractured ribs**
Duration **Aug 5 - 40**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **Aug 5 - 40**

(c) Where did injury occur? **highway**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway (Specify type of place) (e) Means of injury **auto accident**

While at work? _____ (e) Means of injury **auto accident**

23. Signature **M. C. Fisher** (M. D. or other) **!**

Address **Hannibal Mo.** Date signed **Sept 3 40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4
5

e. 2

40

210m
98

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

Carl Abbott

Registered Apprentice No. 229

working under my personal supervision.

Signed E. D. Sprague

Licensed Embalmer No. 3245

P. O. Address Palmyra, Mo.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32539**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Hannibal**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME **William Young**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color **cal** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **32** Months **11** Days **17** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **40** year **1980** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Lung abscess** Duration _____

Due to **Auto Injury**

fractured ribs

Due to **fractured ribs**

Other conditions **following** (Include pregnancy within 3 months of death)

Major findings: **none** Of operation _____

Of autopsy **none**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc**

(b) Date of occurrence **Aug 5 1980**

(c) Where did injury occur? **highway** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **state highway**

(e) While at work? _____ (Specify type of place) (f) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JK

From Highway Report - 12-5-40
Struck a bridge -
Finest object.