

Registration District No. **893**

Primary Registration District No. **6203**

Registrar's No. **11**

1. PLACE OF DEATH: **Webster, FORDLAND, Mo.**
 (a) County **Webster**
 (b) City or town **EAST BENTON TOWNSHIP**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 -X
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **X** **20**
 In this community **15 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Webster**
 (c) City or town **E. BENTON TOWNSHIP**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **RURAL**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **X** years.

3. (a) PRINT FULL NAME **Bert Young**
 (b) If veteran, name war **X** (c) Social Security No. **X**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **September** day **20**
 year **1940** hour **2** minute **30** P.M.
 21. I hereby certify that I attended the deceased from **Jan-15**
 1940, to **Sept 15**, 1940
 that I last saw him alive on **Sept 15**, 1940
 and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Lizzie Young**
 6. (c) Age of husband or wife if alive **56** years
 7. Birth date of deceased **September 15-1889**
 (Month) (Day) (Year)

Immediate cause of death
Acute dilatation of heart

8. AGE: Years **61** Months **no** Days **5**
 If less than one day **X** hr. **X** min.

Due to **Pulmonary Tuberculosis**

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

Due to

10. Usual occupation **Farmer**

Other conditions (include pregnancy within 3 months of death) **27**

11. Industry or business **Farm**
 12. Name **William Young**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Bela Stever**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Ralph Young**
 (b) Address **Sand Springs, Oklahoma**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence

17. (a) **Burial** (b) Date thereof **Sept. 22 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

(c) Place: burial or cremation **Wetch Cemetery**
 18. (a) Signature of funeral director **W. J. Rainey**
 (b) Address **Marshfield, Missouri**

(Specify type of place) (a) Means of injury **3**
 While at work?

19. (a) **Sept 30 40** (b) **Lester W. Reed**
 (Date received local registrar) (Registrar's signature)

23. Signature **Will Spencer** (M.D. or other) **D.O.**
 Address **Marshfield** Date signed **Mo.**

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.

1940-1941 X-15111

RECEIVED

District Health Officer No. 6,

District File Number 1040-2687

Date Filed OCT 9 1940

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.

Signed

Tex Loring

Licensed Embalmer No. 312

P. O. Address Marshfield, 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, above space should be left blank.

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