

Registration District No. 1102 Primary Registration District No. 5870 Registrar's No. _____

1. PLACE OF DEATH
(a) County Penns cot
(b) City, or town Bragg City
(If outside city or town limits, write "RURAL" and name of township)
(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 6 years _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Penns cot
(c) City or town Bragg City
(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.

3. (a) PRINT FULL NAME Julia B Young
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 6
year 1940 hour 12 minute 15 A.M.

4. Sex Female 5. Color or race Col
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Ellis Young 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Nov 2 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Oct 10, 1940, to Nov 6, 1940;
that I last saw her alive on Oct 10, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 4 If less than one day
hr. _____ min. _____

Immediate cause of death Myocarditis
Due to Bright's Disease
Due to Bragg
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

9. Birthplace Fry's Point Miss
(City, town, or county) (State or foreign country)
10. Usual occupation _____

11. Industry or business _____
MOTHER FATHER { 12. Name Robt Armstrong
13. Birthplace Virginia (City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Don't know 9 (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(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?
591 (Specify type of place)
While at work? _____ (e) Means of injury _____

16. (a) Informant Mary Brown
(b) Address Bragg City MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-40
(Month) (Day) (Year)
(c) Place: burial or cremation Kenett MO
18. (a) Signature of funeral director Kenett Funeral Home
(b) Address Kenett MO
19. (a) Nov 6-40 (Date received local registrar) (b) Mrs T. R. Cole (Registrar's signature)

23. Signature William F Pitt (M. D. or other) _____
Address Fry's Date signed 11/6/40

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

13-46
X23159

FILED DEC 11 1940

12-40-16

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FEB 15 1950

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.....

Licensed Embalmer No.....

P. O. Address.....

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. 39449

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1102

Primary Registration District No. 5870

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Pascala
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
In this community _____ (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME Julia B. Young

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

4. Sex Female 5. Color or race Cal 6. (a) Single, widowed, married, divorced wid

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 57 Months - Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

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. (c) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) Nov-6-40 (b) Mrs. J. R. Cole
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 6 year 1940 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 _____

Due to _____

Due to _____

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) _____

(b) Date of occurrence _____

(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?

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

23. Signature Wm J Pitt (M. D. or other) _____

Address Hayti Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-39449 -1940