

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

39896

1. PLACE OF DEATH  
 County Schuyler Registration District No. 804 0118 File No. \_\_\_\_\_  
 Township Saline River Primary Registration District No. 664-9 Registered No. \_\_\_\_\_  
 City Greentop (No. 2) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Luther Owen Young  
 (a) Residence No. Green Top St. Green Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 34 yrs. 0 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Orra B. Young

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29, 1871

7. AGE YEARS MONTHS DAYS  
69    5    24  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Furniture + Undertaking  
 (b) General nature of industry, business, or establishment in which employed (or employer) owner  
 (c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Greentop  
 (STATE OR COUNTRY) Schuyler Missouri

10. NAME OF FATHER William Young  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) North Carolina  
 (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER Louisa Hodges  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Stone Mountain  
 (STATE OR COUNTRY) Claborne Co. Tenn.

14. INFORMANT W. L. Young  
 (Address) Greentop, Missouri

15. FILED Nov 25 1940 Mrs O P Harrington REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-23 1940

17. I HEREBY CERTIFY, That I attended deceased from Nov 27, 1940, to Jan 7, 1940  
 that I last saw h. alive on Nov 27, 1940 and that death occurred, on the date stated above, at 7:50 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Nephritis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Allen D. Do.  
 , 19 (Address) Greentop Mo

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greentop Cemetery DATE OF BURIAL Nov. 25, 1940  
 20. UNDERTAKER William N. West ADDRESS Green City, 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.

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**CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No.....)..... St..... Ward.....

**2. FULL NAME**

(a) Residence. No..... St..... 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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.
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**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

14. INFORMANT (Address).....

15. FILED..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

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.....m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

..... (duration)..... yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

..... (duration)..... yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.  
 , 19 (Address)

\*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

PARENTS

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