

Registration District No. \_\_\_\_\_

Primary Registration District No. 200Registrar's No. 14

## 1. PLACE OF DEATH:

(a) County Adair  
 (b) City or town Kirksville Rural  
 (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 Fifty years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Nancy Emily Young

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex female5. Color or race white6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife David Young

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 25 1870

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

70421

hr. \_\_\_\_\_ min.

9. Birthplace Lancaster Missouri

(City, town, or county)

(State or foreign country)

10. Usual occupation Homedomestic home

11. Industry or business \_\_\_\_\_

12. Name Milton Theodoer Isral13. Birthplace Lancaster Missouri

(City, town, or county)

(State or foreign country)

14. Maiden name Rhoda Locket15. Birthplace Lancaster Missouri

(City, town, or county)

(State or foreign country)

16. (a) Informant Mrs. Kenneth Stevens(b) Address 716 St. Baltimore, Kirksville17. (a) Burial (b) Date thereof 1-19-41

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation Greentop Cemt.18. (a) Signature of funeral director Laura A. Riley(b) Address Kirksville, Mo.19. (a) Jan 19-1941 (b) Spencer L. Freeman

(Date received local registrar)

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair  
 (c) City or town Kirksville Rural  
 (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.? 0 years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1941 hour 11 minute 3021. I hereby certify that I attended the deceased from Dec 30, 1940 to Jan 17, 1941that I last saw her alive on Jan 15, 1941 and that death occurred on the date and hour stated above.Immediate cause of death Uremic poison Duration 3 daysDue to arterio sclerosis 3 years

Due to \_\_\_\_\_

Other conditions Nephroses 2 years  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 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) \_\_\_\_\_

(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? \_\_\_\_\_

3 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. M. Callum (M. D. or other) 1941Address Kirksville Mo. Date signed Jan 20 1941

FILED FEB 23 1941

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RECEIVED

District Health Officer No. 10

District File Number 2-41-364

Date Filed FEB 19 1941

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 Laura A. Riley

Licensed Embalmer No. 3907

P. O. Address Kirksville Md

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1557

Registration District No. 1

Primary Registration District No. 200

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County Adair  
 (b) City or town Kennettville T.P.  
 (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)

## 3. (a) PRINT FULL NAME

Marcy Emily Young

3. (b) If veteran,
- 
- name war \_\_\_\_\_

3. (c) Social Security
- 
- No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married,  
divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if  
alive \_\_\_\_\_ year  
7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 21 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 \_\_\_\_\_  
 (Burial, cremation, or removal) (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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Month
- 1
- day
- 17
- 
- year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;
- 
- that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,
- 
- and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis  
of the heart  
and  
arterio Sclerosis  
of the brain  
830  
 Duration \_\_\_\_\_

- Due to \_\_\_\_\_  
 Other conditions Hemiplegia  
Cerebral Hemorrhage  
 (Include pregnancy within 3 months of death)

- Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 PHYSICIAN  
 Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

## 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?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_
- 
- Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

S-1557