DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1711

FILED FEB 14 1941

Registration District No. 68 — Primary Registration District No. 5103 — Registrar's No.

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.

1. PLACE OF DEATH:

(a) County: Bollinger

(b) City or town: Marquand, Mo
(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 years, months or days)
In this community: All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo, (b) County: Bollinger

(c) City or town: Marquand, Mo,
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location): 0

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Goerge Washington Yount

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Oct (Month) 6 (Day) 1855 (Year)

8. AGE: Years 85 | Months 2 | Days | If less than one day: hr. min.

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

10. Usual occupation: Farmer.

11. Industry or business:

FATHER
12. Name: Jacob Yount.
13. Birthplace: Bollinger Co, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mayfield
15. Birthplace: Bollinger (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: [signature]

(b) Address: Marquand, Mo

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

(c) Place: burial or cremation: Slinkard Cemetery

18. (a) Signature of funeral director: Baker Funeral Home,

(b) Address: Lutesville, Mo.

19. (a) Jan 24 41 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6th year 1940 hour 2. minute P M.

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

Immediate cause of death: No medical attendance — Duration

Due to:

Due to:

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: No medical attendance (M. D. or other)

Address: Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17 11

Registration District No. 68 Primary Registration District No. 5107 Registrar's No.

1. PLACE OF DEATH:
(a) County Ballinger
(b) City or town Marion (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 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) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Geo Washington Young
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
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 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant John H Young
(b) Address Marquand mo
17. (a) (Burial, cremation, or removal) (b) Date thereof Dec 6 40 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) July 18, 41 (Date received by local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: no medical attention	
Due to Death	
Due to old age	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed 7-18-41

S-1711