

S. No. 2  
-11-10-39  
5-17-39  
PI X21492

DEPARTMENT OF COMMERCE  
BOARD OF HEALTH

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36381

Registration District No. 875

Primary Registration District No. 662

Registrar's No. 314

1. PLACE OF DEATH:

(a) County Monroe

(b) City or town Amul - Washington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hosp # 32  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 yrs 8 months  
(Specify whether years, months or days)

In this community 12 yrs 8 months  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Amul City  
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown  
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Addie Young

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

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24  
year 1941 hour 7 minute 35 A. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Judson Young

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

7. Birth date of deceased 4 1961  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 15, 1939, to Oct. 24, 1941;  
that I last saw her alive on Oct. 23, 1941;  
and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 7 Days 20  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Influenza Meningitis  
Due to Secondary to influenza  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name Peter Gore

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

14. Maiden name Sarah Washington

15. Birthplace West Virginia  
(City, town, or county) (State or foreign country)

Major findings: Of operations 338

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

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

16. (a) Informant Dr. Reed

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 10/25/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Newada Mo

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

19. (a) 10-25-41 (b) Allen V. Hays  
(Date received local registrar) (Registrar's signature)

23. Signature Wm. J. Cremer (M. D. or other) \_\_\_\_\_

\*Address Newada Date signed 8/28/41

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

08  
00

RECEIVED

District Health Officer No. 7;

District File Number 11-41-1818

Date Filed 11-7-41

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 Me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

Mike E. Ferry

Licensed Embalmer No. 1432

P. O. Address Nevada 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.