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20499

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

2620

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution Lakeside Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days  
(Specify whether years, months or days) 15 days

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Lecton Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Young

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day ninth year 1942 hour 12 minute 38 AM.

21. I hereby certify that I attended the deceased from 23 1942 to July 9 1942  
that I last saw him alive on July 9th 1942  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race W

6. (a) Single, widowed married divorced \_\_\_\_\_

6. (b) Name of husband or wife FE young

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

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

Immediate cause of death hypostatic pneumonia

Due to prostatectomy + complications

Due to 137a

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

8. AGE: 71 Years Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

Major findings: Prostatic Hy pertrophy

Of operations July 7, 1942

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

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

MOTHER-FATHER

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Wife F Young

(b) Address Lecton Mo

17. (a) Buried (b) Date thereof 7-11-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lecton Mo

18. (a) Signature of funeral director J P Wagner

(b) Address Lecton Mo

19. (a) 7/8/42 (b) \_\_\_\_\_  
(Date received local registrar) (Date received state registrar)

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 1

23. Signature R P Owen (M. D. or other) DD

Address Lakeside Hosp. Date signed 7-9-42

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

*General Director*  
has been queried  
for additional  
information. If  
he replies will for-  
ward the information  
to you.

**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 *J. W. Brumby*  
.....  
Licensed Embalmer No. *3397*  
.....  
P. O. Address *Lector 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 2620

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

1. PLACE OF DEATH:

(a) County Lackson County  
(b) City or town Lackson City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Lackson Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME William Young

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Effie Irene Young 6. (c) Age of husband, or wife, if alive 60 years

7. Birth date of deceased. June 6, 1871  
(Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Farmer

12. Name George Young

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

14. Maiden name Mary Carter

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

16. (a) Informant June Effie Young

(b) Address Lackson, Mo.

17. (a) Lackson, Mo. (b) Date thereof 7-11-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lackson, Mo.

18. (a) Signature of funeral director P. A. Brauning

(b) Address Lackson, Mo.

19. (a) 10/10/42 (b) M. H. Crow  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town Lackson  
(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.

20. DATE OF DEATH: Month 7 day 9  
year 1942 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 \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

APPLIED INTERNALLY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-26499