

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

29687

State File No. _____

FILED OCT 7 1942
Registration District No. _____

Primary Registration District No. 5037

Registrar's No. 138

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

1. PLACE OF DEATH:
 (a) County Cudican, Rural
 (b) City or town Clark, Mo. R. R.
 (c) Name of hospital or institution: 1st name Salt River camp
 (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

3. (a) PRINT FULL NAME: John Thomas 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 2 divorced

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Dec 29 1854
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 8 21 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
 12. Name Ephraim Young
 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Fecrusa Smith
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Atlanta Kelly
 (b) Address Clark, Mo. R. R.

17. (a) Burial (b) Date there 9/22/42
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Maundon

18. (a) Signature of funeral director Margaret H. Machie
 (b) Address Maundon, Mo.
 19. (a) 9-22-42 (b) Margaret H. Machie
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Cudican
 (c) City or town 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 Sept. day 20
 year 1942 hour 9 minute A. M.
 21. I hereby certify that I attended the deceased from June 4
 1941 to Sept 17 1942
 that I last saw him alive on Sept. 17 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
rt. + left lungs
 Duration _____

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 108

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Dr. Joseph H. Jones (M. D. or other) D.O.
 Address Sturgeon, Mo Date signed 9/22/42

RECEIVED

District Health Officer No. 10

District File Number 10-42-1790

Date Filed OCT. 2 1947

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. 1490

P. O. Address.....

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.