

No. 1
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11591

ED APR 12 1943

State File No.

Registration District No. 320

Primary Registration District No. 6081

Registrar's No.

1. PLACE OF DEATH

(a) County St. Genevieve Union
(b) City or town Farmington 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 Security Six years (Specify whether years, months or days)
In this community Security Six years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

J. N. Young

3. (b) If veteran name war

3. (c) Social Security No.

4. Sex Male

5. Color or Race C

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

6. (b) Name of husband or wife Loretta Wesley Young

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Feb 9 1856
(Month) (Day) (Year)

8. AGE: 85-5 Years

Months

Days If less than one day

9. Birthplace French Village St. Francois Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name James Young

13. Birthplace French Village St. Francois Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Susan Allen

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

16. (a) Informant Miss Ida Young

(b) Address Farmington Mo.

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

(c) Place: burial or cremation Three Rivers St. Thomas Co. Mo.

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

(b) Address Farmington Mo.

19. (a) April 4 43 (b) Rev. W. H. Garner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Genevieve
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1943 hour 3 minute 30 a.m.

21. I hereby certify that I attended the deceased from April 1
1943 to April 1, 1943
that I last saw him alive on Mar 31, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hyperthyroidism
Gravitational

Due to serum changes

Due to arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

Duration
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)
(c) Means of injury

23. Signature L. M. Starfield (M. D. or other)
Address Farmington Mo. Date signed 4/1/43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 443-2084

Date Filed 4-9-43

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.....

Chas. M. [Signature], Registered Apprentice No.....
working under my personal supervision.

Signed Chas. M. [Signature]

Licensed Embalmer No. 4084

P. O. Address Farmington, 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

State File No. 11591
Registrar's No. _____

Registration District No. 320 Primary Registration District No. 6081

1. PLACE OF DEATH:
(a) County St. Genevieve
(b) City or town Union Twp. Farmington (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 _____ (Specify whether _____)
In this community _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME J. N. Young
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race White 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 9 1905
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ Of less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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) April 43 (b) Rev Joseph G. Gassner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Genevieve
(c) City or town Farmington Rural Route 2
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April Day 20 Year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him/her _____ 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 _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

supplementary report 29-43

S-11591