

No. 2
9-4-41
17-39
X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18326**
Registrar's No. **61**

FILED JUN 2 1943
Registration District No. **20**

Primary Registration District No. **3040**

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

1. PLACE OF DEATH:
 (a) County **Livingston**
 (b) City or town **Chillicothe**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
420 Ninth St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **60** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Joseph V Young**
 3. (b) If veteran, name war **—**
 3. (c) Social Security No. **—**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced, **married**
 6. (b) Name of husband or wife **Mary Jane Young**
 6. (c) Age of husband or wife if alive **51** years
 7. Birth date of deceased **March - 6 - 1888**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 - 2 - 22 hr. **—** min.

9. Birthplace **Orange Calif**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Grocery Farmer**

11. Industry or business **—**

MOTHER FATHER
 12. Name **Victor Young**
 13. Birthplace **Franklin** (City, town, or county) (State or foreign country) **5**
 14. Maiden name **Mary Young**
 15. Birthplace **Franklin** (City, town, or county) (State or foreign country) **5**

16. (a) Informant **Mrs Mary Jane Young**
 (b) Address **420 Ninth St Chillicothe Mo**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 4 1943**
 (Month) (Day) (Year)

(c) Place: burial or cremation **Chillicothe Mo**
 18. (a) Signature of funeral director **James W Gordon**
 (b) Address **Chillicothe Mo**

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Livingston**
 (c) City or town **Chillicothe**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **420 Ninth St**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **—**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **28**
 year **1943** hour **19** - minute **20** - a.m.
 21. I hereby certify that I attended the deceased from **Jan 15**
 19 **42** to **May 28** 19 **43**
 that I last saw **him** alive on **May 28** 19 **43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Heart decompensation** Duration **1 week**
 Due to **Hypertension** **10 years**
 Due to **Chronic Myocarditis** **3 years**

Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations **X**
 Of autopsy **X 938**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **X**
 (b) Date of occurrence **X**
 (c) Where did injury occur? (City or town) (County) (State) **X**
 (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 **P. J. Brennan** (M.D. or other)
 Address **Chillicothe Mo** Date signed **5/31/43**

SEP 22 1947

STATE OF MISSOURI
DEPARTMENT OF PROFESSIONAL REGULATION

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 Keith Collier
Licensed Embalmer No. 3632
P. O. Address Chillicothe 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.

Registration District No. 187

Primary Registration District No. 3040

Registrar's No.

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(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

Joseph V. Young

3. (b) If veteran, name war _____ (c) Social Security No. _____

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

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

7. Birth date of deceased March (Month) 1 (Day) 1943 (Year)

8. AGE: Years 65 Months 2 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 31-1943 (Date received local registrar) (b) Lois Elba Curry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 28 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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)
(b) 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 _____ (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—... A PERMANENT RECORD

SUPPLEMENTARY

5-18324