

FILED SEP 18 1944

Registration District No. 336

Primary Registration District No. 6128

1. PLACE OF DEATH

(a) County Shannon  
(b) City or town Rural - Excelsior Intp  
(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 1  
(Specify whether)

In this community  
years, months or days

3. (a) PRINT FULL NAME Amanda Rebecca Young - Huling

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

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

6. (b) Name of husband or wife Daniel Young 6. (c) Age of husband or wife if alive 85 years

7. Birth date of deceased Jan 12 - 1860  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 3 If less than one day hr. min.

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

10. Usual occupation Wife

11. Industry or business Wife

12. Name James Huling

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

14. Maiden name Mary McDaniel

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

16. (a) Informant Janice Loglow

(b) Address Excelsior Mo

17. (a) Burial (b) Date thereof Aug 16-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Country

18. (a) Signature of funeral director none

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

19. (a) 8-15-44 (b) Frank Hyde MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon  
(c) City or town Rural - Excelsior Intp  
(If outside city or town limits, write "RURAL")

(d) Street No. 1 (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Polar Pneumonia

Due to \_\_\_\_\_

Due to Injury - fractured Rib ✓

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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

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) (e) Means of injury \_\_\_\_\_

23. Signature Frank Hyde MD (M.D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 8-15-44

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

744

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number.

Date Filed

944489  
9-15-44

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.....

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 236

Primary Registration District No. 6128

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

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Rural Eminence Twp.  
(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 years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) County \_\_\_\_\_

(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

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

(d) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Amenda R. Young

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

(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1944 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 Lobar pneumonia

4. Sex F

5. Color or race W

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

(b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: Jan 12  
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days \_\_\_\_\_  
If less than one day

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

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

Due to injury - fracture rib

Due to \_\_\_\_\_

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

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) Accident - Fall

(b) Date of occurrence Aug-1-44

(c) Where did injury occur? Bank Home, Shannon, MO  
(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 Frank Toyde (M. D. or other) \_\_\_\_\_

Address Eminence, MO Date signed 8-13-44

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

SUPPLEMENTAL

31903