

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9353

State File No. _____

FILED APR 14 1945

3010

Registrar's No. 87

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau

(c) Name of hospital or institution: St Francis

(d) Length of stay: In hospital or institution 7 days

In this community 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill

(b) County Alexander

(c) City or town Olive Branch

(d) Street No. _____

(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME HOWARD O. 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 Jane Young

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Feb 8 - 1883

8. AGE: Years 62 Months 1 Days 15

If less than one day hr. _____ min. _____

9. Birthplace Amos Co Ill

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name John Young

13. Birthplace Tenn

14. Maiden name Eliza Miller

15. Birthplace Amos Co Ill

16. (a) Informant Mrs. Henry Poulless

(b) Address Olive Branch, Ill.

17. (a) Burial

(b) Date thereof md 25-45

(c) Place: burial or cremation Delta

18. (a) Signature of funeral director F.A. Karber

(b) Address 322

19. (a) 3-28-45

(b) F.K. Phelps

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23 year 45 hour 12 minute 30P M.

21. I hereby certify that I attended the deceased from 3/10 1945 to 3-23 1945 that I last saw him alive on 3-29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Aneurism

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 730

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

23. Signature [Signature] (M. D. or other) _____

Address [Address]

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 4

District File Number 445-47

Date Filed 4-9-45

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 Frank A. Kaucher

Licensed Embalmer No. 2103

P. O. Address Loais Ill

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.