

FILED APR 19 1945

Registration District No. 238

Primary Registration District No. 5823

Registrar's No. 68

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town New Madrid Gambouj
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: NO
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution: NO
In this community 1918 years, months or days (Specify whether)

3. (a) PRINT FULL NAME JEFF YOUNG
3. (b) In Veteran name war NO 3. (c) Social Security No. NO

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Ella Young 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased: MARCH-10-1871 (Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 11 If less than one day hr. min.

9. Birthplace: Work Alabama (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farming

MOTHER FATHER { 12. Name Jon Young
13. Birthplace Work Alabama (City, town, or county) (State or foreign country)
14. Maiden name Work
15. Birthplace Work Alabama (City, town, or county) (State or foreign country)

16. (a) Informant J. E. Young, Jr.

(b) Address New Madrid, Mo.

17. (a) Funeral (b) Date thereof: 2/25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Sanhill

18. (a) Signature of funeral director: Richard Lind Co

(b) Address New Madrid, Mo.

19. (a) 3-13-45 (b) Helen Lou Jones (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town 17 (If outside city or town limits, write "RURAL")
(d) Street No. 1 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21 year 1945 hour 11:00 minute P.M.

21. I hereby certify that I attended the deceased from May 30, 1943, to Jan 30, 1945, that I last saw him alive on Jan 30, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Cardio-Renal Disease - + Pneumonia Duration _____

Due to Nephritis - Hypertension

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 O. B. Chandler (M. D. or other) MD

Address New Madrid Date signed 3/8/45

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2

District File Number 448-2

Date Filed APR 11 1945

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 *Leo H. Edgworth*
Licensed Embalmer No. *3503*
P. O. Address *New Madrid 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.

2B
43
36930

State File No. may
Registrar's No. 680

Registration District No. 238 Primary Registration District No. 5823

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town 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)

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

4. Sex m 5. Color or race B 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 June 10 1965
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 1
Year 1965 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Chronic Nephritis

Due to _____

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

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 J.B. Chandler (M.D. or other) _____

Address 4728 1/2 S Date signed _____

New Madrid Mo

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

SUPPLEMENTARY

14104