V. S. No. 2
0M—8-43
ev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 23549

FILED AUG 3 1945

Registration District No. ____ Primary Registration District No. 1000 Registrar's No. 799

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MERCY HOSPITAL 823 FARAONO
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County GENTRY
(c) City or town R.F.D. #2, STANBERRY (If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #2 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME LORIE MAYLEE YOUNT
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex FEMALE | 5. Color or race WHITE | 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN COBURN YOUNT
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased OCT. (Month) 14 (Day) 1878 (Year)

8. AGE: Years 66 | Months 7 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace unknown (City, town, or county) 9 (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business FARM
MOTHER FATHER
12. Name unknown
13. Birthplace ____ (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) 9 (State or foreign country)
16. (a) Informant MRS. JULIA ALLDREDGE
(b) Address 2616 EAST 29 KANSAS CITY MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (Month) (Day) (Year)
(c) Place: burial or cremation Island City Cemetery Co
18. (a) Signature of funeral director Asbury J. Phillips
(b) Address Maryville Mo
19. (a) 7-23-45 (Date received local registrar) (b) Helen Hickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1945 hour 8 minute 20 P. M.
21. I hereby certify that I attended the deceased from July 16, 1945, to July 21, 1945, that I last saw h[illegible] alive on July 21, 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Intestinal Obstruction | 3 days |
| Due to: Cancer of the Sigmoid | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |

Major findings: Of operations Cancer of Sigmoid
Of autopsy —
460

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? ____ (Specify type of place)
While at work? ____ (e) Means of injury 2

23. Signature [signature] (M. D. or other) D.O.
Address 823 Faraon St Joseph Mo Date signed 7-23-45

1577 (Licensed Embalmer's Statement on Reverse Side)

## 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: Latony H. Phillips

Licensed Embalmer No. 1898

P. O. Address Sterling Md

**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.**