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**FILED SEP 8 1945 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_  
Registrar's No. 54

Registration District No. 206 Primary Registration District No. 5747

**1. PLACE OF DEATH:**  
 (a) County Madison  
 (b) City or town Madison, Mo.  
 (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** CORA MAE YOUNG  
**(b) If veteran,** \_\_\_\_\_ **(c) Social Security** \_\_\_\_\_  
 name war \_\_\_\_\_ No. \_\_\_\_\_

**4. Sex** F **5. Color or race** W  
**6. (a) Single, widowed, married, divorced** M  
**(b) Name of husband or wife** Wes Young **(c) Age of husband or wife if alive** 69 years  
**7. Birth date of deceased** MAY 21 - 1878  
 (Month) (Day) (Year)

**8. AGE:** Years 67 Months 2 Days 23  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** MARYOLAND MO - 0  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** HOUSE WIFE

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER** { **12. Name** WM - DAVIS  
 { **13. Birthplace** MARYOLAND MO  
 { **14. Maiden name** Esther Robbins  
 { **15. Birthplace** MARYOLAND MO  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** DULMAN young  
**(b) Address** Madison Mo

**17. (c) (Burial, cremation, or removal)** \_\_\_\_\_ **(b) Date thereof** 8-14-45  
 (Month) (Day) (Year)  
**(c) Place: burial or cremation** MARYOLAND, MO

**18. (a) Signature of funeral director** Edw. H. ...  
**(b) Address** Madison Mo

**19. (a) Date received local registrar** Aug 14 1945 **(b) S. C. Straighter**  
 (Date received local registrar) (Registrar's signature)  
481 Bay 2 (Licensed Embalmer's Statement on Reverse Side)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Madison  
 (c) City or town Madison, Mo.  
 (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 AUG day 13  
 year 1945 hour 1 minute \_\_\_\_\_ P. M.

**21. I hereby certify that I attended the deceased from** several years 19 \_\_\_\_\_ to Aug 13 1945  
 that I last saw her alive on Aug 11 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Membranous and cerebral haemorrhage  
 Due to chronic nephritis  
 Duration 3 days  
2 years

Due to \_\_\_\_\_  
 Other conditions Hypertension  
 (Include pregnancy within 3 months of death) 4 years

**Major findings:**  
 Of operations \_\_\_\_\_  
 Of autopsy 1211  
**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 0

**23. Signature** S. C. Straighter (M. D. or other)  
 Address Fredericktown Mo Date signed 8-14-45

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

RECEIVED

District Health Officer No. 4  
District File Number 945-2-1050  
Date Filed 9-6-45

**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.....

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.**

Registration District No. 206

Primary Registration District No. (5747)

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Orange and Joplin 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 Coramial Young  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 8

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 2 (Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) S. C. Slaughter (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 Aug Day 3 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 \_\_\_\_\_

Duration \_\_\_\_\_

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

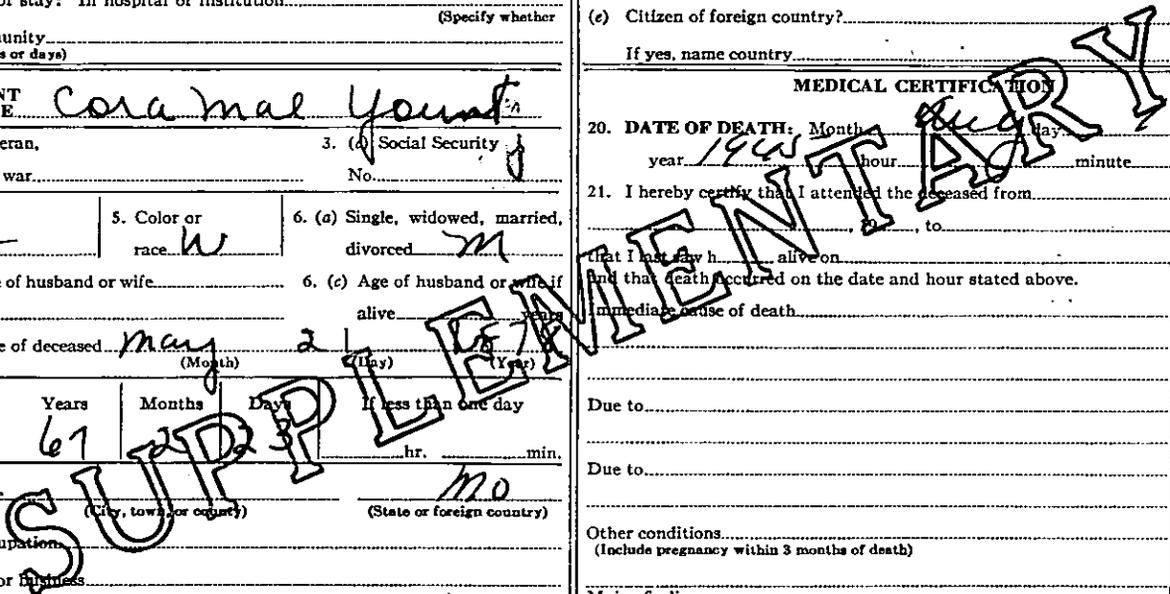
PHYSICIAN \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



S-27869