

STANDARD CERTIFICATE OF DEATH

Registration District No. 378

Primary Registration District No. 4552

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Mountain Grove  
(c) Name of hospital or institution Ryan Hospital  
(d) Length of stay: In hospital or institution 14 days  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Green 39  
(c) City or town Springfield M 2  
(d) Street No. 6  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

IDA B YOUNG

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. NONE

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

6. (b) Name of husband or wife E. C. Young 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 29 1874 (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Wright Co, Mo (City, town, or county) (State or foreign country)

10. Usual occupation housewife

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

MOTHER FATHER { 12. Name Thomas Pearman

13. Birthplace Ky 1 (City, town, or county) (State or foreign country)

14. Maiden name Robert E. Hogan

15. Birthplace Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ethel Hendley

(b) Address Springfield, Mo

17. (a) Burial (b) Date thereof 9-16-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Creek Cem

18. (c) Signature of funeral director Gene E. Holden

(b) Address Hartsville Mo

19. (a) 10-3-45 (b) A. B. Ames (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15 year 1945 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from 8/31, 1945 to 9/15-45 that I last saw her alive on 9/15-45 and that death occurred on the date and hour stated above.

Immediate cause of death Brights disease & cystitis

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

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? \_\_\_\_\_

23. Signature R. A. Ryan (M. D. or other) Address Mountain Grove, Mo Date signed 9/20-45

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

STATEMENT BY LICENSED EMBALMER

*Not*

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

*Gene E. Halbrun*

Licensed Embalmer No. *3865*

P. O. Address *Hartwell, Ma*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. NovRegistration District No. 378Primary Registration District No. 4553Registrar's No. 158

## 1. PLACE OF DEATH:

- (a) County Wright  
 (b) City or town Int Grove  
 (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 days3. (a) PRINT  
FULL NAMEIda B. Young

3. (b) If veteran,
- 
- name war \_\_\_\_\_

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if
- 
- alive \_\_\_\_\_

7. Birth date of deceased
- Jan 29 1871
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- 
- 71
- 7
- 17
- mo
- 
- hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_
- 
- (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 \_\_\_\_\_ Day \_\_\_\_\_
- 
- Year
- 1945
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration

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

- 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
- R.A. Ryan
- (M. D. or other) \_\_\_\_\_

- Address
- Int Grove
- Date signed \_\_\_\_\_

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

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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