

No. 2
8-43
17-39
X37823

FILED JUN 14 1946

Registration District No. **10** Primary Registration District No. **3002**

1. PLACE OF DEATH:

(a) County **Audrain**

(b) City or town **Mexico**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Audrain Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 hour**
(Specify whether years, months or days)

In this community **20 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Audrain**

(c) City or town **Mexico**
(If outside city or town limits, write "RURAL")

(d) Street No. **807 N. Washington St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **John A. Young**

3. (b) If veteran, name was **None**

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 **Estelle Young**

6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **April 1, 1885**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 1 22 hr. min.

9. Birthplace **Paris, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Truck driver**

11. Industry or business

MOTHER FATHER

12. Name **James Young**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Young**
(b) Address **Mexico, Mo.**

17. (a) Burial (b) Date thereon **May 25, 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Walnut Grove, Paris, Mo.**

18. (a) Signature of funeral director **Earl S. Pruss**
(b) Address **Mexico, Mo.**

19. (a) May 25/46 (b) **Blanche Keely**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **23**
year **1946** hour **11 15** minute **9** M.

21. I hereby certify that I attended the deceased from **Coroner's Case**, 19____, 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 **The the jury came to the conclusion that the death, by taking Poison, Strychnine**

Due to **Young came to his death, by taking Poison, Strychnine**

Due to **Poison, Strychnine**

Other conditions **Young & Coroner**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**

Of autopsy **none**

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? _____

(e) Means of injury **3**

While at work? **Yes**

23. Signature **S. C. Adams** (M. D. or other) **Coroner**
Address **Mexico, Mo.** Date signed **5-23-46**

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

MAR 24 1967

OCT 14 1954

RECEIVED

District Health Officer No. 10

District File Number 6-46-1215

Date Filed JUN-1-3-1946

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.....

Earl E. Precht

....., Registered Apprentice No.....

working under my personal supervision.

Signed Earl E. Precht

Licensed Embalmer No. 3189

P. O. Address Mexico, 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.

Registration District No. 10

Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Mexico
(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 John A. Young

3. (b) If veteran _____ name war _____

3. (c) Social Security No. _____

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 _____ years

7. Birth date of deceased April
(Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ (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 _____
(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 May Day 23 Year 1946 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 _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy none

Duration _____

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) Suicide

(b) Date of occurrence May 23 - 1946

(c) Where did injury occur? home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Took the train on his home
(Specify type of place)

While at work? No (e) Means of injury Train

23. Signature J. C. Adams (M. D. or other) _____

Address Mexico Mo Date signed 7-26-46

14528 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MAR 24 1967

15037