

**FILED FEB 20 1947**

Registration District No. **21947**

Primary Registration District No. **4320**

Registrar's No. **13**

1. PLACE OF DEATH:  
(a) County **Marion**  
(b) City or town **Palmyra**  
(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 **Not Known** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Marion**  
(c) City or town **Palmyra**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **115 E. Olive** (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **Berdet Franklin Young**  
3. (b) If veteran, name war **XXXXXXXXXXXXXXXXXX**  
3. (c) Social Security No. **XXXXXXXXXXXXXX**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Feb.** day **6**  
year **1947** hour **10 P.M.** minute..... M.

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Wid**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **Dec. 29 1861**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 1946**, to **February 6, 1947**  
that I last saw him alive on **February 6, 1947**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Serivility** Duration.....

8. AGE: Years **85** Months **I** Days **7** If less than one day  
hr. min.

Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations.....  
Of autopsy.....

9. Birthplace **Marion County Mo.** (City, town, or county) (State or foreign country)  
10. Usual occupation **Retired**

11. Industry or business.....  
12. Name **Marquis Young**  
13. Birthplace **Ky.** (City, town, or county) (State or foreign country)  
14. Maiden name **Not Known**  
15. Birthplace **Not Known** (City, town, or county) (State or foreign country)

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?

16. (a) Informant **From Funeral Records of Sister**  
(b) Address.....

17. (a) **Palmyra** (b) Date thereof **2 8 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Greenwood Cem.**  
18. (a) Signature of funeral director **A M Sprague**  
(b) Address **Palmyra Mo**  
19. (a) **2-11-1947** (b) **Vesta Reed, Deputy**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury **0**  
23. Signature **Marion Kishorian** (M. D. or other) Address **Palmyra Mo** Date signed **2/8/47**

WRITE PLAINLY—USE UNFEDERATED CAPITAL LETTERS

MOTHER, FATHER

**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..... *R. G. Sprague* .....  
Licensed Embalmer No..... *999* .....  
P. O. Address..... *Palmyra 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 209

Primary Registration District No. 4820

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Palmyra  
(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 Berdet J. Young

3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced, widowed

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

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

8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 3-26-47 (b) Em Luke (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 7 day \_\_\_\_\_ year 1947 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 \_\_\_\_\_

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) \_\_\_\_\_

Date signed \_\_\_\_\_

SUPPLEMENTARY

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

S-5487