

S. No. 2
M-5-43
5-17-39
I X3687

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28380

FILED **CCD 2** 1947
Registration District No. 270

Primary Registration District No. 5769

Registrar's No. 61

1. PLACE OF DEATH, **Mercer**
(a) County **Mercer**
(b) City or town **Lindley Twnp/**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **all his life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Mercer** **65**
(c) City or town **Lindley Twnp.** **6**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____
(If rural, give location) **0**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **no**

3. (a) PRINT FULL NAME **Robert M. Young**
(b) If veteran, name war **no**
(c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **21**
year **1947** hour **4** minute **00 A.M.**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced, **widowed**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from **August 5**, 19**47**, to **August 21**, 19**47**, that I last saw him alive on **August 21**, 19**47**, and that death occurred on the date and hour stated above.

7. Birth date of deceased **Oct 14, 1869**
(Month) (Day) (Year)
8. AGE: Years **78** Months **10** Days **7**
If less than one day _____ hr. _____ min.

Immediate cause of death **Carcinomatosis** Duration **1 yr**
Due to **Carcinoma of Prostate** **4 years**
Due to _____

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **farmer**

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations **510**
Of autopsy _____

MOTHER FATHER {
11. Industry or business _____
12. Name **William H. Young**
13. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **McAfee**
15. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **James Young**
(b) Address **Weathbey, Mo**
17. (a) **Burial** (b) Date thereof **Aug 23, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

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 _____

(c) Place: burial or cremation **Bethel**
18. (a) Signature of funeral director **Noel Moss**
(b) Address **Princeton, Mo**
19. (a) **8-22-47** (b) **M. J. Reith**
(Date received local registrar) (Registrar's signature)

23. Signature **M. J. Reith** (M. D. or other) **MD**
Address **Princeton, Mo** Date signed **8/23/47**

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

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 Me

....., Registered Apprentice No.
working under my personal supervision.

Signed

Paul Matt

Licensed Embalmer No.

2634

P. O. Address

Junston 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.