

FILED AUG 29 1947

State File No. \_\_\_\_\_

Registration District No. 377

Primary Registration District No. 4553

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

1. PLACE OF DEATH:

(a) County WRIGHT  
(b) City or town MANSEFIELD  
(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 40 yrs  
years, months or days

3. (a) PRINT FULL NAME CLARA MAY YOUNG

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased MARCH 21 1875  
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace FONTANA KANSAS  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

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

12. Name JOHNSON D CASIDA

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

14. Maiden name MARY ELLYN SPROCK

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

16. (a) Informant Louis P. Casida

(b) Address MANSEFIELD MO

17. (a) BURIAL (b) Date thereof AUG 14-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PRAYER HOLLOW GRAN

18. (a) Signature of funeral director J.A. Bluffe

(b) Address MANSEFIELD MO

19. (a) 8/18/47 (b) Ruth Stout - Dept  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WRIGHT  
(c) City or town MANSEFIELD  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 17  
year 1947 hour 1 minute 30 A M.

21. I hereby certify that I attended the deceased from July 24 1947 to Aug 16 1947  
that I last saw her alive on Aug 16 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 weeks

Due to Hypertension

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

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

Major findings:  
Of operations 83A  
Of autopsy \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

(c) 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? \_\_\_\_\_

(Specify type of place) While at work \_\_\_\_\_ (e) Means of injury 2

23. Signature M.A. Zimmerman (M. D. or other) PO

Address Mansefield Mo Date signed 8/18/47

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

507

RECEIVED

District Health Officer No. 6,

District File Number 847-924

Date Filed AUG 28 1947

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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

*F. A. Steffe*

Licensed Embalmer No. 3221

P. O. Address

*Manfred Md*

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.