

No. 2  
5-43  
17-39  
X36671

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

FILED DEC 30 1947  
Registration District No. 227

Primary Registration District No. 4339

Registrar's No. 70

1. PLACE OF DEATH:

(a) County MONROE

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

(c) Name of hospital or institution:  
W. CALDWELL ST. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 76 YEARS

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONROE

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

(d) Street No. W. CALDWELL ST.  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME ALONZO RAYMOND YOUNG

3. (b) If veteran, name war NO

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 NETTIE YOUNG

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased MARCH 10 1871  
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 14 If less than one day hr. min.

9. Birthplace RANDOLPH Co. MO G  
(City, town, or county) (State or foreign country)

10. Usual occupation PAINTER + CARPENTER

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

MOTHER FATHER { 12. Name WILLIAM YOUNG

13. Birthplace MONROE Co. MO. G  
(City, town, or county) (State or foreign country)

14. Maiden name MARGARET FARRIS

15. Birthplace MONROE Co. MO. G  
(City, town, or county) (State or foreign country)

16. (a) Informant Sadie Roberts

(b) Address Paris, Mo.

17. (a) BURIAL (b) Date thereof 12-26-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ORX GROVE CEM.

18. (a) Signature of funeral director Speed Orakey

(b) Address PARIS, MO.

19. (a) 12-24-47 (b) Elbert Baker M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 24 TH. year 1947 hour 8 AM.

21. I hereby certify that I attended the deceased from Nov 2 1947 to Dec 24 1947 that I last saw him alive on Dec 23 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to Fracture Hip

Duration 1 hr 20 min

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)

23. Signature W. M. Roberts (M. D. or other) \_\_\_\_\_

Address PARIS, MO. Date signed 12-24-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION

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

RECEIVED  
District Health Officer No. 10  
District File Number 12-47-1816  
Date Filed DEC 29 1947

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..... *A. G. Blakey* .....  
Licensed Embalmer No. *2616* .....  
P. O. Address..... *Paris 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. Jan 70  
Registrar's No. \_\_\_\_\_

Registration District No. 227 Primary Registration District No. 4339

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

1. PLACE OF DEATH:  
(a) County Monroe  
(b) City or town Paris  
(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 Alanzo R 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 Married  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Mar 10 1930  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ 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 \_\_\_\_\_  
(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 \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_  
186A  
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22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Fall in horse  
(b) Date of occurrence Nov 2 - 1947  
(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? Home

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Alanzo R Young (a) B or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed Jan 16 1970

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

SUPPLEMENTARY

42424