

S. No. 300
OM - 10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12890**
Registrar's No. **1713**

FILED MAY 7 1948 **149**
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Little Sisters of the Poor**
5361 Highland Ave.
(If not in hospital or institution, write "Home" and name of residence)
(d) Length of stay: In hospital or institution **1 1/2 years**
(Specify whether years, months or days)
In this community **27 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **705 East 23rd St.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs Helen Young**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **18th**
year **1948** hour **3.25** P.M. minute _____ M.
21. I hereby certify that I attended the deceased from **April 18**
1948 to **April 18**, 19**48**
that I last saw her alive on **4/16/48**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Henry Young** 6. (c) Age of husband or wife if alive **----** years
7. Birth date of deceased **Dec. 25, 1862**
(Month) (Day) (Year)

Immediate cause of death **Cardiac failure**
Due to **arteriosclerosis, coronary heart disease**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations **no** **430**
Of autopsy **no**

8. AGE: Years **85** Months **3** Days **23**
If less than one day hr. _____ min. _____

PHYSICIAN
Underline the cause to which death should be charged statistically.
Duration **1 day**
10 days

9. Birthplace **Ironton, Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

11. Industry or business _____
12. Name **No record**
13. Birthplace **No record** (State or foreign country) **9**
14. Maiden name **No record**
15. Birthplace **No record** (State or foreign country) **9**

16. (a) Informant **Mrs Agnes McMerrell**
(b) Address **705 East 23rd St.**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
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? **0**

17. (a) **Burial** (b) Date thereof **April 20, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. St. Mary's**
Chos. E. Quirk Funeral Home

18. (a) Signature of funeral director: **4316 Troost Ave.**
(b) Address _____
19. (a) **4-19-48** (b) **Theraldine Holmes**
(Date received local registrar) (Registrar's signature)

23. Signature **Robert [unclear]** (M. D. or other) **MD**
Address **1102 [unclear]** Date signed **4-19-48**

J. E. 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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Thomas E. Quirk

Licensed Embalmer No.

3775
R. O. Mo.

P. O. Address.....

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.