

No. 2
-43
1759
33867

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 13 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15766

State File No. _____

Registration District No. 73

Primary Registration District No. 4134

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Way

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

(c) Name of hospital or institution:
NO NUMBER
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community one week
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Way

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

(d) Street No. none
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES P. Young.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race wh

6. (a) Single, widow, married, divorced not

6. (b) Name of husband or wife E. Dna Young

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased may 14 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58 11 23 hrs. min.

9. Birthplace Monticello Mo
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Thomas G. Young

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

14. Maiden name Marion Jones

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

16. (a) Informant Mrs. Ward Young

(b) Address Smithville Mo

17. (a) Burial (b) Date thereof 5/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Providence Cemetery

18. (a) Signature of funeral director Paul Kitchey
(Funeral director's signature)

(b) Address Smithville Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1948 hour 30 minute 2 M.

21. I hereby certify that I attended the deceased from April 30
1948 to May 7 1948;

that I last saw him alive on May 7 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of pharynx

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 458

Major findings: Of operations _____

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:

(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 R. E. Speelman (M. D. or other) _____

Address Smithville Mo Date signed 5/7/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 5-17-48

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.....

Licensed Embalmer No. 4448

P. O. Address Liberty

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. June
Registrar's No. xy

Registration District No. 72 Primary Registration District No. 4134

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Smithville
(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

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 _____

3. (a) PRINT FULL NAME Charles C. Young
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____
year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I did not see him/her _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Edna Young 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased May 14 (Month) (Day) (Year)

Duration _____
Due to _____
Due to _____

8. AGE: Years 58 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace Monticello (City, town, or county) Kentucky (State or foreign country)

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

10. Usual occupation _____
11. Industry or business _____
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)

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?
_____ (Specify type of place)
While at work? _____ (e) Means of injury _____

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other)
Date signed _____
Address _____

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

MOTHER FATHER

SUPPLEMENTARY

RECEIVED THE DEPT. OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

5-15766