

FILED JUN 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18944**

BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **70**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Excelsior Springs, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (In this place) 1 yr 10 mo		d. STREET ADDRESS (If rural, give location) 2021 No. 11th Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Veterans Administration			

3. NAME OF DECEASED (Type or Print) a. (First) Walter	b. (Middle) --	c. (Last) Young	4. DATE OF DEATH (Month) (Day) (Year) June 21 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Sept. 20, 1890	9. AGE (In years last birthday) 58	10. MONTHS 	10. DAYS 	10. HOURS 	10. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal mining	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME John Young	13b. MOTHER'S MAIDEN NAME Mary Wall	14. NAME OF HUSBAND OR WIFE --
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I	16. SOCIAL SECURITY NO. 356 16 2778	17. INFORMANT'S SIGNATURE OR NAME Hospital records, Veterans Administration	ADDRESS Excelsior Spgs.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION Tuberculosis, pulmonary, reinfection type, far advanced, active. Severe symptoms.		INTERVAL BETWEEN ONSET AND DEATH Unknown
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b)		
DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				102X

19a. DATE OF OPERATION --	19b. MAJOR FINDINGS OF OPERATION --	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) --	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) --
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) --	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? --
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22. I hereby certify that I attended the deceased from **Aug. 22, 1947**, to **June 21, 1949** that I last saw the deceased alive on **June 21, 1949**, and that death occurred at **6:10 pm.**, from the causes and on the date stated above.

23a. SIGNATURE S. C. Stroff (Degree or title) M. D.	23b. ADDRESS Excelsior Springs, Mo.	23c. DATE SIGNED 6-22-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 22 1949	24c. NAME OF CEMETERY OR CREMATORY Oakridge Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Illinois
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DATE REC'D BY LOCAL REG. X	REGISTRAR'S SIGNATURE 621 Virginia Hope Ex Springfield Mo	25. FUNERAL DIRECTOR'S SIGNATURE Virginia Hope Ex Springfield Mo	ADDRESS --
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUN 28

District Health Officer No. 8,

District File Number _____

Date Filed _____

676168711
6-28-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed James A. Moles
Licensed Embalmer No. 3526

P. O. Address Excelsior Spgs

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.