

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **412**

FILED FEB 9 1953

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **131**

3117
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hosp.		d. STREET ADDRESS (If rural, give location) 2424 Patee St.	

3. NAME OF DECEASED (Type or Print) a. (First) Forest b. (Middle) B. c. (Last) Young			4. DATE OF DEATH (Month) (Day) (Year) Jan. 28, 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 1, 1911	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr.-Cashier		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	11. BIRTHPLACE (State or foreign country) Rockport, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Virgil B. Young	13b. MOTHER'S MAIDEN NAME Rita Teare	14. NAME OF HUSBAND OR WIFE Maxine Young
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY (If yes, give war or dates of service) W.W.#2 491-09-0849	17. INFORMANT'S SIGNATURE OR NAME Mrs Maxine Young	ADDRESS 2424 Patee
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		6 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Atherosclerosis DUE TO (c) Hypertension, essential		1 year. 3 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201	

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-29, 1952**, to **1-28, 1953**, that I last saw the deceased alive on **1-27, 1953**, and that death occurred at **5:00pm.**, from the causes and on the date stated above.

23a. SIGNATURE W. D. Barle (Degree or title)	23b. ADDRESS 706 Figgins St. Joseph, Mo.	23c. DATE SIGNED 1/28/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-30-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. Jan 31, 1953	REGISTRAR'S SIGNATURE Carl C. Cash	25. FUNERAL DIRECTOR'S SIGNATURE Norman W. Sidenfaden	ADDRESS 1802 Union St.
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FEB 11 1953

STATEMENT BY LICENSED EMBALMER

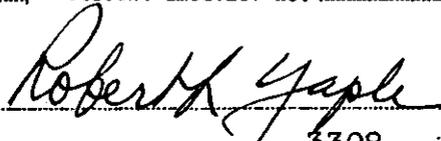
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.