

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

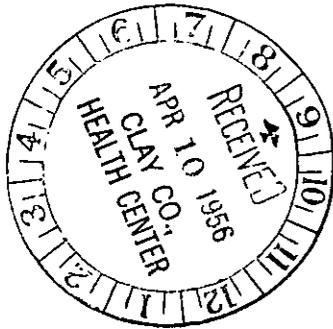
8465

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>83</u>	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>British Columbia</u> COUNTY <u>Vancouver</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Excelsior Springs</u> )		c. LENGTH OF STAY (in this place) <u>5 Days</u>		c. CITY OR TOWN <u>Vancouver</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</u>				STREET ADDRESS (If rural, give location) <u>5597 Commercial Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>ARCHIBALD</u>		a. (First)		b. (Middle)		c. (Last) <u>YOUNGS</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Whita</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug 14 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Letter Cr.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Beccles Suffolk England</u>		9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>13</u> Min.	
12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>		13a. FATHER'S NAME <u>Peter Youngs</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Canada Florence M. Young-B.C. Vanc.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.#1Canada</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Florence M. Youngs-Canada, B.C. Vanc.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Staphylococcus Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) starting the underlying cause last. DUE TO (b) <u>Recture Duodenal Ulcer and Gastric Resection (Sub Total)</u> DUE TO (c) <u>Arteriosclerosis -</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>9 days</u> <u>years</u>	
19a. DATE OF OPERATION <u>3/28/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Rectured Uterus</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. 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) _____		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 <u>3/23</u> , 19 <u>56</u> , to <u>3/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27/56</u> , 19 <u>56</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u>		(Degree or title) <u>MD</u>		23b. ADDRESS <u>Excelsior Springs, Mo</u>		23c. DATE SIGNED <u>3/28/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/30/1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery-B.C. Vancouver-Canada</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>4/1/56</u>		REGISTRAR'S SIGNATURE <u>Barlene Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil Hays</u>		ADDRESS <u>Excelsior Spgs Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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



APR 10 1956

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, [Signature] ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed James A. Mole.....

Licensed Embalmer No. 3296

P. O. Address Excelsior S.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.