

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000068  
STATE FILE NUMBER

FILED JAN 13 1959 Registration District No. 4 Primary Registration District No. Registrar's No. 106

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Alchion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Alchion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rock-Port Mo</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fairfax Hospital</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>6 mi N.W. Rock Port</u>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Nancy</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1878</u>		9. AGE (In years last birthday) <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Alchion Co</u>		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <u>John Young</u>		13b. MOTHER'S MAIDEN NAME <u>Mirisah Winters</u>		14. NAME OF HUSBAND OR WIFE <u>Happie Mae Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>496-42-0511</u>		17. INFORMANT Address <u>Mrs. Happie Mae Young - Rock-Port Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>trauma - cont. cerebral circulation of heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1810</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Secondary aneurism. Dil. &amp; aneurism of blood vessels</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 5-17-48 to Jan 4, 1959 and last saw her alive on Jan 3-1959  
Death occurred at \_\_\_\_\_ m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thermin H. Schoeler</u>	22b. ADDRESS <u>Rock-Port Mo</u>	22c. DATE SIGNED <u>1-4-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1/6/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hunter Cemetery</u>	23d. LOCATION (City, town, or county) <u>S-Rock-Port Mo</u>	(State)
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24. FUNERAL DIRECTOR <u>Deane Funeral Home - Rock-Port Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Jan 8, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Thermin H. Schoeler</u>
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Item 8 & 9 added by query of Funeral Director  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE 2-9-59

All diseases in Part I must be causally related.  
 Doctor, Coroner, etc. must use only standard nomenclature in item 10. NO abbreviations will be tolerated.

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 By Me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed J. B. Bertram.....  
Licensed Embalmer No. 4024.....  
P. O. Address Rock Port 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.