

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024110

FILED VS JUL 21 1959

STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. \_\_\_\_\_ Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>BOLLINGER</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RURAL CROOKED GREEK</u>		Length of stay in 1b <u>LIFETIME</u>		c. CITY OR TOWN <u>RURAL</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NEAR MARQUAND</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>NEAR MARQUAND</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>THOMAS EDGAR YOUNT</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>29</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>3-15-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JONATHAN YOUNT</u>			13b. MOTHER'S MAIDEN NAME <u>CORDELIA BROOKS</u>		14. NAME OF HUSBAND OR WIFE <u>WILLENE YOUNT</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>491-30-5647</u>		17. INFORMANT Address <u>Ms WILLENE YOUNT, Marquand Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)			<u>Acute circulatory failure</u>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Coronary Artery Occlusion</u>				
			DUE TO (c) <u>Coronary Atherosclerosis</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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	
21. I attended the deceased from <u>Dead upon Arrival</u> and last saw her/him alive on _____ Death occurred at <u>7 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Glen E. Kinkead</u> Coroner				22b. ADDRESS <u>Lutesville Mo.</u>		22c. DATE SIGNED <u>July 13, 1959</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7-14-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PATTON CEMETERY</u>		23d. LOCATION (City, town, or county) <u>PATTON Mo.</u>		
24. FUNERAL DIRECTOR <u>Baker Funeral Home, Lutesville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7/16/59</u>		26. REGISTRAR'S SIGNATURE <u>Ms. Buford Crader</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.