

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032921

FILED VS SEP 29 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 86

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in lb <u>Life</u>		c. CITY OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>216 N. 24th. St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>216 N. 24th. St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RHONDA DEE YOUNG</u>				4. DATE OF DEATH Month Day Year <u>September 10 1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/10/59</u>	9. AGE (last birthday) <u>0</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>1</u> Min.	IF UNDER 24 HR Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Floyd Young</u>			13b. MOTHER'S MAIDEN NAME <u>Evelyn Jane Welch</u>			14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>		17. INFORMANT Address <u>Floyd Young Lexington, 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>Congenital Alecterans</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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>Sept. 10, '59</u> to <u>Sept. 10, '59</u> and last saw her <u>alive</u> on <u>Sept. 10, '59</u>				Death occurred at <u>2:04</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>John C. Bellison D.O.</u> (Degree or title)				22b. ADDRESS <u>Lexington, Mo.</u>			22c. DATE SIGNED <u>9/11/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 11, '59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Machpelah Cemetery</u>		23d. LOCATION (City, town, or county) <u>Lexington</u>		STATE <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>Crunk-Walker</u> ADDRESS <u>Lexington, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-14-59</u>		26. REGISTRAR'S SIGNATURE <u>Marian Stentland</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 Harold S. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington,

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.