

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035214

FILED VS OCT 26 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 499

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>3 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Auroria</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route # 2 -</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Franklin</u> Last <u>Younts</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</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>12-11-88</u>		9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>Everton, Missouri</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>John Joseph Younts</u>				13b. MOTHER'S MAIDEN NAME <u>Anna Surilda</u>				14. NAME OF HUSBAND OR WIFE <u>Mary Etta Younts</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.				17. INFORMANT <u>Hospital Records</u> Address _____							
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>Probable Renal Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> DUE TO (b) <u>Prostatic obstruction</u> <u>6-12 Mos</u> DUE TO (c) <u>? Benign Prostatic Hypertrophy</u> <u>5-10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obstructive Jaundice Probably 2° to abdominal</u>										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.) <u>Carcinomatosis</u>											
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>October 16 1959</u> to <u>October 19 1959</u> and last saw <u>him</u> alive on <u>October 19 1959</u> Death occurred at <u>1:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Henry D. Obern M.D.</u>						22b. ADDRESS <u>Ellis Fischel St. Cancer Hosp</u>				22c. DATE SIGNED <u>Oct 19 1959</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Oct. 20, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Auroria, Mo.</u>				23d. LOCATION (City, town, or county)		(State)					
24. FUNERAL DIRECTOR ADDRESS <u>Parker Funeral Serv. Columbia, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>Oct 20 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 27 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 _____
Signature of Student Embalmer

Signed

J. M. Phillips

Licensed Embalmer No. 4897

P. O. Address Columbus

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.