

FILED VS FEB 23 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-005435  
STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Carrolton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lexington 05420</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ketzel Hospital</b>		Length of stay in lb <b>5 Days</b>	d. STREET ADDRESS (If outside, give location) <b>405 North 17th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARRIE JONES YOUNG</b>			4. DATE OF DEATH Month Day Year <b>2 - 17 - 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1872</b>		9. AGE (In years last birthday) <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Lexington, Missouri</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Not known</b>		13b. MOTHER'S MAIDEN NAME <b>Carrei Clayton</b>	
13c. NAME OF HUSBAND OR WIFE <b>John C. Young</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mary Klapp, Lexington, Missouri</b>		17. INFORMANT Address		17. INFORMANT 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) <i>Spinally &amp; Shock</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>fractured left hip</i> DUE TO (c) <i>9040</i>					INTERVAL BETWEEN ONSET AND DEATH <i>days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>21-</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <i>Fell in home</i>			
20c. TIME OF INJURY Hour a.m. <i>2</i> Month, Day, Year <i>13 60</i>		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.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION <i>Lexington</i>		20f. COUNTY STATE <i>Lafayette Mo</i>	
21. I attended the deceased from <i>2-13-60</i> to <i>2-17-60</i> and last saw her alive on <i>2-17-60</i> Death occurred at <i>9:30 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert C. [Signature]</i>			22b. ADDRESS <i>Carrollton Mo</i>		22c. DATE SIGNED <i>2-17-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-20-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Machpelah</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington, Missouri.</b>
24. FUNERAL DIRECTOR <i>Garrett F. [Signature]</i>		25. DATE RECD. BY LOCAL REG. <i>2-19-60</i>		26. REGISTRAR'S SIGNATURE <i>Marlene [Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

VS MAR 28 1960

STATEMENT BY LICENSED EMBALMER

MAR 11 1960

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 *Garrett G. Gumpel*

Licensed Embalmer No. *3205*

P. O. Address *Lexington*

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.