

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1960

-60-029458

Registration District No. 372 Primary Registration District No. 6263 Registrar's No. 12 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>DOUGLAS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>F. N. KEY TOWNSHIP</u>		Length of stay in 1b	c. CITY OR TOWN <u>AVA</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ROUTE 1</u>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>BOBBY JOE YOUNG</u>			4. DATE OF DEATH Month Day Year <u>7-27-60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1930</u>	9. AGE (last birthday) <u>30</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>WEBSTER Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>WILLIAM W. YOUNG</u>		13b. MOTHER'S MAIDEN NAME <u>ROSAMOND VANDALL</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.		17. INFORMANT Address <u>MRS. ROSAMOND YOUNG AVA, MO. RT 1</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>Basal Skull Fracture</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, to which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Depression fracture Temporo parietal area</u>	
	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>Numerous abrasions on face + neck + lower lip on left side</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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Struck on head with 410 Shotgun</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>1030 7-27-60</u>	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.) <u>farm home</u>	20f. CITY, TOWN, OR LOCATION <u>Seymour R2</u>	COUNTY <u>Webster</u>	STATE <u>Mo</u>

21. I attended the deceased from about 1030 p to and last saw her/him alive on .
Death occurred at on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. Edwards Coroner</u>		22b. ADDRESS <u>Marshfield Mo</u>		22c. DATE SIGNED <u>7/30/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-31-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FANNON CEMETERY</u>		23d. LOCATION (City, town, or county) <u>DOUGLAS Co. MO.</u>
24. FUNERAL DIRECTOR <u>Robert Bergman</u>		25. DATE RECD. BY LOCAL REG. <u>Seymour, Mo Aug 2-1960</u>		26. REGISTRAR'S SIGNATURE <u>Gilbert Jones</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

AUG. 8 1960

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Monroeville

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