

**FEDERAL BUREAU OF INVESTIGATION**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-034213**

**FILED VS SEP 29 1960**

STATE FILE NUMBER

Registration District No. 74 Primary Registration District No. 5295 Registrar's No. 35

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clinton</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Concord Township</u>		Length of stay in 1b <u>1 year</u>		c. CITY OR TOWN <u>Lathrop</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warren Baumeler Nur.Ho.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Hattie</u> Last <u>Young</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>19</u> Year <u>1960</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-12-1874</u>		<b>9. AGE (last birthday)</b> <u>86</u>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Ray County Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>					
<b>13a. FATHER'S NAME</b> <u>Alexander Anderson</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>Edna Kennedy</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>Tom G. Young (Deceased)</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Price Anderson Holt, Missouri</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Coronary Occlusion</u>										<u>6 hrs.</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)								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					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY		STATE					
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.</b> Death occurred at <u>8:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <u>Edna Young, D.A. Coroner</u>						<b>22b. ADDRESS</b> <u>Lathrop, Mo.</u>				<b>22c. DATE SIGNED</b> <u>9-20-60</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>9-21-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lathrop Cemetery</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>Lathrop Missouri</u>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Crunk Funeral Home Lathrop, Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-21-1960</u>				<b>26. REGISTRAR'S SIGNATURE</b> <u>Mary W Searee</u>					

(Licensed Embalmer's Statement on Reverse Side)

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 P. Reich

Licensed Embalmer No. 499

P. O. Address Lathrop,

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.