

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042647

FILED VS NOV 22 1960/74

Registration District No. \_\_\_\_\_ Primary Registration District No. 3644 Registrar's No. 106

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington Township</b>			Length of stay in Tn <b>30 years</b>		c. CITY OR TOWN <b>Lexington (rural)</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1/2 Mi. S. of Lex.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R.F.D. 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>MAY</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>26 September 1906</b>	9. AGE (last birthday) <b>54</b>	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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (City and state or country) <b>Higginville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Lutzie Kranz</b>			13b. MOTHER'S MAIDEN NAME <b>Pauline Mueller</b>			14. NAME OF HUSBAND OR WIFE <b>Marshall A. 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>None</b>		17. INFORMANT Address <b>Marshall A Young Lexington, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Skull Fracture</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
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 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.) <b>Motor Car Collision</b>					
20c. TIME OF INJURY Hour <b>10.00</b> a.m. Month, Day, Year <b>11-10-60</b>							
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <b>of the death 6-11-60</b>		20f. CITY, TOWN, OR LOCATION <b>Odesa Lexington Lafayette Mo.</b>			
21. I attended the deceased from <b>of the death 6-11-60</b> to <b>10:00 AM</b> and last saw him/her alive on <b>11-10-60</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. Martin MD Coroner</b>				22b. ADDRESS <b>Odesa Mo</b>		22c. DATE SIGNED <b>11-10-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/12/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lexington Memory Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington, Mo</b>		
24. FUNERAL DIRECTOR <b>Waghn-Walker Lexington, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>11-12-60</b>		26. REGISTRAR'S SIGNATURE <b>W. Martin</b>	

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, Va.

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.