

# OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045476

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 147

STATE FILE NUMBER

FILED DEC 26 1961

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

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
<u>Samuel T Young</u>			<u>12</u>	<u>15</u>	<u>1961</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-86</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Duties</u>	11. BIRTHPLACE (City and state or country) <u>Truxton Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Douglas</u>	13b. MOTHER'S MAIDEN NAME <u>Martha I Aspley</u>	14. NAME OF HUSBAND OR WIFE <u>Zera D. Young Deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Rosalie Hoff. Ballflower Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>  <u>4 DAYS</u>
IMMEDIATE CAUSE (a)	<u>PULMONARY EDEMA</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	DUE TO (b) <u>PNEUMONIA</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>FRACTURE RT HIP ON 11/11/61</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 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.)
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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
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21. I attended the deceased from <u>11/4/61</u> to <u>12/15/61</u> and last saw <sup>her</sup> him alive on <u>12/15/61</u> Death occurred at <u>12:10</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Loni P. Deltos MD</u>	22b. ADDRESS <u>Troy, Mo</u>	22c. DATE SIGNED <u>12/18/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-,961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fines</u>	23d. LOCATION (City, town, or county) (State) <u>Near Truxton Mo.</u>
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24. FUNERAL DIRECTOR <u>Oland A. Jones Bellflower Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-18-1961</u>	26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>
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DATE FURNISHED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

JAN 4 1962

**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 Edward G. Jones

Licensed Embalmer No. 2978

P. O. Address Bellflower

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.