

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045503

AMENDED

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 118

STATE FILE NUMBER

FILED DEC 28 1961

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

3. NAME OF DECEASED (Type or print) First Middle Last <b>RALPH OTTWAY YOUNT</b>	4. DATE OF DEATH Month Day Year <b>December 18, 1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 10, 1878</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days <b>9 8</b>	IF UNDER 24 HR Hours Min. <b>8</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and state or country) <b>Bucklin, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Silas M. Yount</b>	13b. MOTHER'S MAIDEN NAME <b>Lucy Morris</b>	14. NAME OF HUSBAND OR WIFE <b>Gertrude Yount (Deceased)</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Russell Yount</b>	Address <b>Bucklin, Missouri</b>
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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
IMMEDIATE CAUSE (a) <i>Pneumonia hyperstatica</i>		<b>4 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Congestive shock failure</i>	<b>1 mo.</b>
	DUE TO (c) <i>Arteriosclerotic shock disease</i>	<b>1 mo.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cachexia</b>	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
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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.) <b>-</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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.) <b>-</b>	20f. CITY, TOWN, OR LOCATION <b>-</b>	COUNTY <b>-</b>	STATE <b>-</b>
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21. I attended the deceased from **Oct 31, 1961** to **Dec 17** and last saw her him alive on **12-17-61**  
Death occurred at **2:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>R. H. Bohm M.D.</i>	22b. ADDRESS <i>Bucklin</i>	22c. DATE SIGNED <b>12/18/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec, 20, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Bucklin, Missouri</b>
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24. FUNERAL DIRECTOR <b>Larson Funeral Service, Bucklin, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>December 19, 1961</b>	26. REGISTRAR'S SIGNATURE <i>Anna Watson</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

**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 E. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, Missouri

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.