

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002445

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 8

FILED JAN 15 1963

DO NOT WRITE ON THIS STUB	AMENDED	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
VS 300 Rev: 4/59					
1 <u>05-95</u>					
2 <u>05-95</u>					
3					
4 <u>1</u>					
5 <u>0</u>					
6					
7 <u>2</u>					
8 <u>2</u>					
9 <u>332X</u>					
10					
11					
12 <u>86-0</u>					
13 <u>1-0</u>					
ITEM NO.	SHOULD READ				
					BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>			Length of stay in 1b <u>80 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</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>Susan's Nursing Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>424 Ninth</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Christina</u> Middle <u>Young</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1963</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/72</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>		11. BIRTHPLACE (City and state or country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Victor Young</u>			13b. MOTHER'S MAIDEN NAME <u>XX</u>		14. NAME OF HUSBAND OR WIFE <u>XX</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> <u>XX</u>			16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT <u>Mrs. Margaret Hinchey, Avalon, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
DUE TO (b) <u>Cerebral Embolus (Paralysis of Rt. side)</u>						<u>8 yrs</u>	
DUE TO (c) <u>  </u>							
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <u>  </u>					
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
21. I attended the deceased from <u>Feb. 10, 48</u> to <u>Jan 5, 63</u> and last saw her <u>him</u> alive on <u>Jan 5, 63</u> Death occurred at <u>6:10 PM</u> on the date stated above, and to the best of <u>my</u> knowledge, from the causes stated.							
22a. SIGNATURE <u>Joseph Conrad M.D.</u> (Degree or title)				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>Jan 11-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 8, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>	
24. FUNERAL DIRECTOR <u>Donald Gordon, Chillicothe, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Jan 11, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Armalee Taylor</u>	

USE BLACK INK OR TYPEWRITER RIBBON

*Date delivered to Mr. Sam b, 1963  
Date recd. from Mr. Sam 11, 1963*

**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 Richard W. Bondall

Licensed Embalmer No. 4866

P. O. Address Chillicothe, Mo.

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.