MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

37497

1. PLACE OF DEATH
County: McDonald — Registration District No.: 1149 — File No.: 1
Township: White Rock — Primary Registration District No.: 5697 — Registered No.: 25
City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Samantha Young
(a) Residence. No. X St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Frank Young
6. DATE OF BIRTH (MONTH, DAY AND YEAR): 11
7. AGE: Years 63 — Months 10 — Days 24 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Ark
(STATE OR COUNTRY): Benton Co

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT (Address): Tom Young
15. FILED 12/29, 1927 Leo Carnell REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12 – 20 – 1927
17. I HEREBY CERTIFY, That I attended deceased from 11 – 10 –, 1927, to 12 – 18, 1927, that I last saw her alive on 12 – 18, 1927, and that death occurred, on the date stated above, at 12 – 20 – 1927 – 4 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abcess of Liver
120
1952
123
(duration) ..... yrs. 1 mos. 14 ds.
CONTRIBUTORY (SECONDARY): Gall stones
(duration) 5 yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? X DATE OF .....
WAS THERE AN AUTOPSY? X
WHAT TEST CONFIRMED DIAGNOSIS? X
(Signed) C. W. Horton, M. D
, 19 (Address) Hiwasse Ark

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: White Rock — DATE OF BURIAL: 12-21 1927
20. UNDERTAKER: W B Russell — ADDRESS: White Rock

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.
County: McDonald — Registration District No.: 1149 — File No.: 21
Township: White Rock — Primary Registration District No.: 2697 — Registered No.: 23
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Samantha Young

(a) Residence. No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1/24/1864

7. AGE: Years 63 — Months 10 — Days 26 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 12/29 19 27 Leo Lowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-20 19 27

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER: W. B. Russell — ADDRESS: Jane, Mo.

SUPPLEMENTARY

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