

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

Do not use this space.

33198

92 1925

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 150
Township Wright Primary Registration District No. H 270
City Allenville, Mo. St. _____ Ward _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Betty Lou Young
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 4 - 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
6 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Allenville, Mo.
(STATE OR COUNTRY) _____

10. NAME OF FATHER Bud Young

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cape Girardeau
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Edith Drum

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Allenville, Mo.
(STATE OR COUNTRY) _____

14. INFORMANT Osceola Drum
(Address) Allenville, Mo.

15. FILED 10/5 1929 J.M. Slagle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-5- 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-30, 1929, to 10-5-, 1929 that I last saw her alive on 10-5-, 1929, and that death occurred, on the date stated above, at 5- P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
107A

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

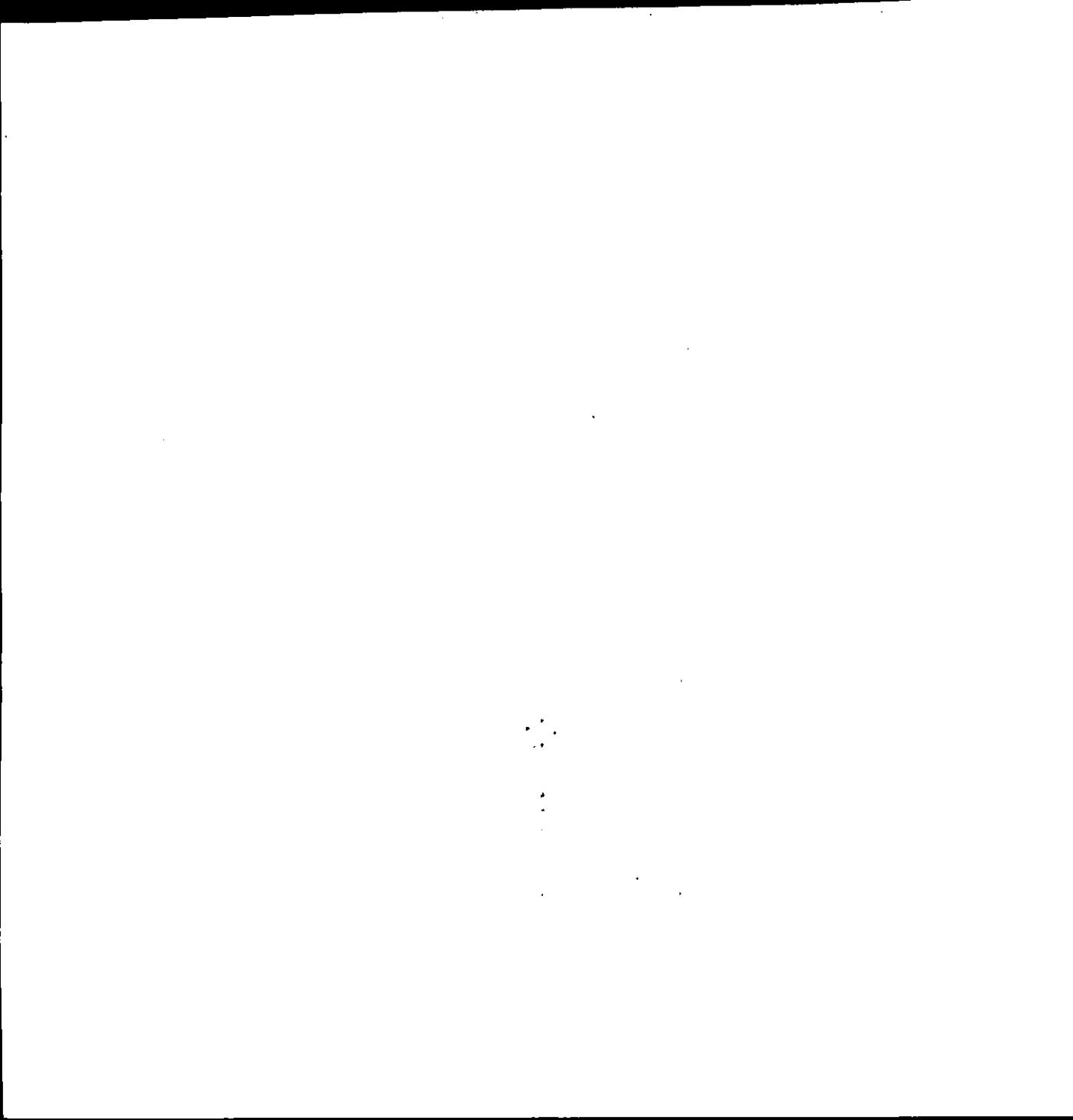
(Signed) F. S. Markel, M. D.
, 19 (Address) Allenville Mo

*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

Allenville Cemetery 10-6 1929
20. UNDERTAKER Burkhoff Girardeau

PARENTS



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 130 File No. 1
 Township Douglas Welch Primary Registration District No. 4073 Registered No. 1
 City (No. St. Ward)

2. FULL NAME

Betty Lou Young
 (a) Residence. No. St. Ward. (If nonresident, give city or town and State)
 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 S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS 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)

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 10/5/29 J. M. Slegel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-5-1929

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:

Obstructed Bronchio
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 10/5/29
 (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

20. UNDERTAKER ADDRESS

REGISTRARS 12 3. GIVE A FE. FO. CERTIFICATED OR 2. IF V. ARE COMPLETE

S-33198