

SEP 24 1930

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

26220

1. PLACE OF DEATH

County ColeRegistration District No. 213File No. 191

Township

Primary Registration District No. 30 1/4Registered No. 191City Jefferson (No.)

St. Ward

2. FULL NAME Susan Young

(a) Residence No. St. Ward. (If nonresident, give city or town and State)

(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 F4. COLOR OR RACE Negro5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1843

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

87

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania co(STATE OR COUNTRY) V.A.10. NAME OF FATHER Nathan Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pennsylvania co, Va.12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) don't know

14.

INFORMANT H. B. Young(Address) 77 E. 1st

15.

FILED 9/23/301930S. M. Bedford

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug - 9 193017. I HEREBY CERTIFY, That I attended deceased from Aug 9 1930 to Aug 9 1930that I last saw her alive on Aug 9 1930 and that death occurred, on the date stated above, at 7 1/2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic endocar-
dites 92 1/2(duration) 16 1/2 yrs. mos. ds.CONTRIBUTORY (SECONDARY) fall + old age(duration) yrs. mos. 1/2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Don't knowDID AN OPERATION PRECEDE DEATH? no DATE OFWAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS Chronic(Signed) E. G. Richardson M. D., 19 (Address) Jefferson City, 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

New city cemetery 8-11-1930

20. UNDERTAKER

ADDRESS

L. D. Hardiman J. E. Mo.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cole Registration District No. 213 File No. _____
 Township Jr City Primary Registration District No. 2014 Registered No. 191
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(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 C 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (per the word) wid

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) _____

FILED 10/9/30 1930 A Beards REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic endocarditis
Fall at home, ruptured
of bed while trying to get up.
 CONTRIBUTORY Fall and old age
 (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 _____

20. UNDERTAKER _____ ADDRESS _____

Information should be carefully stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-26220