

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH: 2
 (a) County Dallas
 (b) City or town Buffalo
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days

3. (a) PRINT FULL NAME Susan M. Young
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 520

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married divorced married
 6. (b) Name of husband or wife E. A. Young 6. (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased 1 8 1876
 (Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Leadmine Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____
 MOTHER FATHER { 12. Name Desert Holloman 9
 18. Birthplace unknown 0
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Lamb
 15. Birthplace Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. A. Young
 (b) Address Buffalo Mo.

17. (a) Buried (b) Date thereof 9-11-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn
 18. (a) Signature of funeral director L. B. Jones
 (b) Address Buffalo Mo.

19. (a) 9-22-39 (b) Harvey Morrow
 (Date received local registrar) (Registrar's signature) 218

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Dallas
 (c) City or town Buffalo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9th
 year 1939 hour 7 minute P M.
 21. I hereby certify that I attended the deceased from 12-23-, 1938, to 9-9-, 1939;
 that I last saw her alive on 9-9-, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration ?

Due to _____

Due to _____

Other conditions Diabetes
 (include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. E. Farrell (M. D. or other) MD
 Address Buffalo, Mo Date signed 9-22-39

APR 5 1943

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1502

Date Filed 10-13-39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.