

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.

NOV 1 1939

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

36114  
Do not use this space.

1. PLACE OF DEATH  
(a) County GREENE Registration District No. 370  
(b) Township SPRINGFIELD Primary Registration District No. 380  
(c) City SPRINGFIELD (d) Street No. Highway 66 Registered No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Milton Burke Young  
(a) Residence, No. 212 S. W. Jefferson St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 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) May 8 - 1919

7. AGE YEARS 20 MONTHS 5 DAYS 21 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
9. Industry or business in which work was done, as saw mill, bank, etc. - -  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greene Co Missouri

FATHER  
13. NAME Ernest B. Young  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER  
15. MAIDEN NAME Dell Haynie  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greene Co Mo.

17. INFORMANT (ADDRESS) E B Young, Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Brookline DATE Oct 31 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Phyllis Schuyler, Springfield Mo

20. FILED Oct 30 1939 Lucy E Hoyal Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 29 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him dead alive on 10-29, 1939. Death is said to have occurred on the date stated above, at 4:20 m.  
The principal cause of death and related causes of importance were as follows:  
Amoked chest  
Extensive lacerations of feet and legs 5th°

Date of onset 10/29/39

Other contributory causes of importance: 212 S W Jefferson

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide accident Date of injury 10/29, 1939  
Where did injury occur? Highway 66, 10 miles west of Springfield  
(Specify city or town, county, and State) Mo.  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Highway  
Nature of injury Spurred with gravel while driving by truck

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) H. H. White M. D.  
(Address) Lawrence Greene Co Mo Springfield

---

---

**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.**