

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

REV. 8-17-39
FORM 1 X1931

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14021

State File No.

1736

Registrar's No.

MAY 15 1940
Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2309 Drury
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 Yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Eunice Young 520

3. (b) If veteran, name war No. 3. (c) Social Security No. 486-07-9970

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Chas. H. Young 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased July 2nd. 1910
(Month) (Day) (Year)

8. AGE: Years 29 Months 9 Days 19 If less than one day hr. min.

9. Birthplace Charenton, La.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ✓ 1

12. Name Aristild La Lande

13. Birthplace La.
(City, town, or county) (State or foreign country)

14. Maiden name Eudene Le Deaux
(City, town, or county) (State or foreign country)

15. Birthplace La.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. Young
(b) Address 2536 Drury Blvd.

17. (a) Burial (b) Date thereof 4 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director H. J. Mayberry
(b) Address 2315 Linwood Blvd.

19. (a) April 23, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2309 Drury (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21st.
year 1940 hour 5 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Oct 1939, 19____, to Apr. 21, 1940;
that I last saw her alive on Apr 20, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Right Emphysema Duration 1 Mo.

Due to Subdiaphragmatic Abscess

Due to Liver Abscess

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy See above

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 1

23. Signature J. M. Young M.D. (M. D. or other)
Address 1901 Drury Blvd. Date signed 4/22/40

125B

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. 2560

P. O. Address 2315 Linwood Blvd.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 1736

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K. C.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

3. (a) PRINT FULL NAME Ernie Young

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

19. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/23/40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr. day 21 - year 40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Sub-diaphragmatic abscess

Due to Liver Abscess

Due to etiology - unknown

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

1250'

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 J. M. Young (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

5-14024