

No. 2  
11-10-39  
-17-39  
I X2149

Registration District No. **470**

Primary Registration District No. **37633**

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County **Lawrence**  
(b) City or town **Mount Vernon**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Missouri State Sanatorium**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **Seven days**  
years, months or days)

3. (a) PRINT FULL NAME **Byron Young**  
8. (b) If veteran, name war **No** 3. (c) Social Security No. **(490-49-8051)**

4. Sex **Male** 5. Color or race **Black** 6. (a) Single, widowed, married, divorced **Married**  
7. (b) Name of husband or wife **Lucille Young** 8. (c) Age of husband or wife if alive **Unknown** years  
7. Birth date of deceased **September 8th 1903**  
(Month) (Day) (Year)

8. AGE: Years **36** Months **9** Days **12** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **Kitchen Helper**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Unknown**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Michael Record Clerk**  
(b) Address **Missouri State Sanatorium**

17. (a) **Removal** (b) Date thereof **June 23, 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jefferson City, Mo**

18. (a) Signature of funeral director **Walter S. Jones**  
(b) Address **100 Jefferson St, Jefferson City**

19. (a) **10-20-1940** (b) **P.A. HOLMES**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cole**  
(c) City or town **Jefferson City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **523 Linn Street**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **20th**  
year **1940** hour **12:25** minute **A** M.

21. I hereby certify that I attended the deceased from **June 13th** 19**40**, to **June 20th** 19**40**;  
that I last saw him alive on **June 19th** 19**40**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis** Duration **1 year**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions **lacerated throat** **3 days**  
(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?

491  
While at work?  (Specify type of place) (e) Means of injury

23. Signature **Maurice L. Jones** (M. D. or other) **1**  
Address **Mt. Vernon, Mo** Date signed **6-20-40**

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

W A Holmes, Reg.

298

113

185

RECEIVED

STATE OF OHIO DEPARTMENT OF HEALTH

10 11

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22148

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town \_\_\_\_\_  
(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 Byron Young  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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 36 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 \_\_\_\_\_  
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH. Month June day 20 - 48  
year \_\_\_\_\_ 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 Pul. tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) Lacerated throat 3 days  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) suicide  
(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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

