

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27635
3249
Registrar's No. _____

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Rau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1514 1/2 Cherry none 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community no
years, months or days) Patsy Lee Young

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. 1514 1/2 Cherry
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Patsy Lee Young 57

8. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug-17-1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>no</u>	<u>no</u>	<u>no</u>	<u>5 hr. 20 min.</u>

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

10. Usual occupation none

11. Industry or business none

12. Name Edward R. Young

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

14. Maiden name Madine Savage

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

16. (a) Informant's own signature Ed R. Young

(b) Address 1514 1/2 Cherry

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

(c) Place: burial or cremation Green Lawn Cen

18. (a) Signature of funeral director A.P. Doehler

(b) Address 1415 5th 15

19. (a) Aug. 18, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17
year 1940 hour 10 minute 20 A. M.

21. I hereby certify that I attended the deceased from 6 AM Aug 17, 1940 to 10:20 AM 8-17-40
that I last saw her alive on 8-17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth Malnutrition

Due to 15 1/2

Due to _____

Other conditions Retent of Urine Orals
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) _____
(a) Means of injury _____

23. Signature M. M. Crowe (M. D. or other) DO
Address 377 1/2 E 7th Date signed 8-17-40

PHYSICIAN
Underline the cause to which death should be charged statistically

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

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 the above constitutes grounds for revocation of license.)

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