

Registration District No. 461

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

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

4. Sex ma 5. Color or race W
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 Jan. 24 1938
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>2</u>	<u>7</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Ralston Young
13. Birthplace Bell Valley Va
(City, town, or county) (State or foreign country)
14. Maiden name Hung Larson
15. Birthplace Albert Lee Minn
(City, town, or county) (State or foreign country)

16. (a) Informant Ralston Young
(b) Address Lexington Mo

17. (a) Burial (b) Date thereof Sept. 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Higginsville, Mo

18. (a) Signature of funeral director Winkler
(b) Address Lexington Mo

19. (a) Sept 9/40 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Lexington
(If outside city or town limits, write "RURAL")
(d) Street No. 6th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 31
year 1940 hour 7 minute 509 M.

21. I hereby certify that I attended the deceased from Aug 25
_____, 1940, to Aug 31, 1940,
that I last saw h IM alive on Aug. 30, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Dysentery
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy Peritonitis, Hemorrhage intestinal mucosa.

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

23. Signature J.S. Cape (M. D. or other) MD
Address Lexington Mo Date signed 9/5/40

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

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

RECEIVED
District Health Officer No. 8,
District File Number
9-11-40

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 Chas. A. McKear

Licensed Embalmer No. 2983

P. O. Address Lexington, Mass.

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.