

REC'D JAN 22 1941

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

44225
Do not use this space.

1. PLACE OF DEATH *Webster*
 (a) County..... *Webster* Registration District No. *896*
 (b) Township..... *of ark* Primary Registration District No. *6198* Registered No. *50*
 (c) City..... *2* (d) Street No. St.
 (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 *P. R. Young*
 (a) Residence, No. *Marshall Elm.* 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 *M* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Annie A. Young*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 29 - 1866*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>74</i>	<i>7</i>	<i>28</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. *Reduce dealer*
 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) *Mo. Mo.*

FATHER

13. NAME *Tom B. Young*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Penn.*

MOTHER

15. MAIDEN NAME *Janie C. Mathis*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Berda Young Dawson Marshall Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Marshall* DATE *Nov. 29* 19*40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. M. Lawton Funeral Home Marshall Mo. 894*

20. FILED *Dec. 12 - 40* 19 *Chelcie Thayer* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov. 27* 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *Nov. 1 - 1940* to *Nov. 27* 19*40*
 I last saw him alive on *Nov. 27* 19*40* Death is said to have occurred on the date stated above, at *8 a. m.*
 The principal cause of death and related causes of importance were as follows:
Chronic Intestinal Nephritis
 Other contributory causes of importance: *171*

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?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) *W. F. Schuchert* M. D.
 (Address) *Marion Mo.*

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.

RECEIVED

District Health Officer No. 0,

District File Number 141-152

Date Filed JAN 16 1944

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 A. J. M. Mahan

Licensed Embalmer No. 1779

P. O. Address Manassas, Va.

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. 44225

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 896

Primary Registration District No. 6198

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Osark T.P.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Peter R. Young
(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
74 7 28 _____ h _____ 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) 2-21-41 (b) Elyse H. Hoff
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Nov day 27
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

Duration
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 _____

23. Signature W. F. Bellicht (M. D. or other) _____
Address Managers home signed _____

SUPPLEMENTAL

