No. 2
-1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24305 2844

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 8 days (Specify whether years, months or days)

In this community 50 yrs 0

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 048 26

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No.: 4316 East 10th St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: ROY YOUREE

3. (b) If veteran, name war: —

3. (c) Social Security No.: None

4. Sex: M 0

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: Feb. 26, 1880 (Month) (Day) (Year)

8. AGE: Years 61 Months 5 Days 0 If less than one day hr. min.

9. Birthplace: Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: David Youree

13. Birthplace: Ky 1 (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Dora Ragan

15. Birthplace: Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant: Leslie Youree

(b) Address: 4316 E. 10th.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-28-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Washington

18. (a) Signature of funeral director: C.H. Blackman & Son

(b) Address:

19. (a) 7-28-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th year 1941 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from 6-18-41, 19..., to 7-26-41, 19...; that I last saw him alive on 7-26-41, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary thrombosis	
Due to: Carcinoma of prostate	
Due to:	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Henry R. Thom (M. D. or other)

Address: Med. Dir. K.C. Gen. Hospital Date signed: 7-28-41

561 (Licensed Embalmer's Statement on Reverse Side)

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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed; fact should be so stated above.

. S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24305

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2844

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: KC General City #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

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) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: Roy Yourse

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: S

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 .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address: City

19. (a) 9/11/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (c) Means of injury .....

23. Signature ..... (M. D. or other)

Address ..... Date signed .....

SUPPLEMENTARY