

FILLED NOV 6, 1941
Registration District No. **6/139A1**

Primary Registration District No. **4-88**
Registrar's No. **13**

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Farmvelt Mo**
(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 **8 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Scott 100**
(c) City or town **Farmvelt** (If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) If foreign born, how long in U. S. A. **✓** **1** years.

3. (a) PRINT FULL NAME **Marguerite D. Young**
3. (b) If veteran, **✓** name war **✓**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **31**
year **1941** hour **12** minute **20 P.** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Mary Robertson**
6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **Feb 26 1886** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 4**, 19**41**, to **Oct 31**, 19**41**, that I last saw him alive on **Oct 31**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **18 months**
Due to **Arteriosclerosis**

8. AGE: Years **80** Months **8** Days **5**
If less than one day **1** hr. **0** min.

Due to **Senility**

9. Birthplace **Murphysboro Ill** (City, town, or county) (State or foreign country)
10. Usual occupation **Watchman**

Other conditions (Include pregnancy within 3 months of death) **938**

11. Industry or business
12. Name **Young**
13. Birthplace **Mont Know 9** (City, town, or county) (State or foreign country)
14. Maiden name **Mont Know**
15. Birthplace **" "** (City, town, or county) (State or foreign country)

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature **Delia Spice**
(b) Address **Farmvelt Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov 1 1941** (Month) (Day) (Year)
(c) Place: burial or cremation **Lightview Cem, Illinois**
18. (a) Signature of funeral director **Dr. P. M. H. H. H. H.**
(b) Address **Illino. Mo.**
19. (a) **Nov 1 1941** (Date received local registrar) (b) **Paul Bray** (Registrar's signature)

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 **Fred W. Martin** (M.D. or other)
Address **Illino** Date signed **11-1-41**

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

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.

NOV 1 1941

RECEIVED

District Health Office No. 2,

District File Number 1141-1489

Date Filed 11/5/41

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.