No. 2
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17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1943

Registration District No. 3 8

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13668

Primary Registration District No. 3006

Registrar's No. 88

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone County Hospital
(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 about 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Columbia
(If outside city or town limits, write "RURAL")
(d) Street No.: 302 N. 7th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: LUCILE YOUNG
3. (b) If veteran, name war: —
3. (c) Social Security No.: —

4. Sex: Female
5. Color or race: Negro
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: 1-11-1913 (Month) (Day) (Year)

8. AGE: Years 30 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Hannibal (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Maid
11. Industry or business: Christian College
FATHER
12. Name: Ollie Young
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name: Lettie Lenaire
15. Birthplace: Marion Co. (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Lettie Lenaire
(b) Address: Columbia Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-3-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cemetery
18. (a) Signature of funeral director: Stuart D. Parker
(b) Address: Columbia Missouri
19. (a) 4-2-'43 (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day March year 1943 hour 4 minute 15 a.m.
21. I hereby certify that I attended the deceased from 3-12-1943 to 3-21-1943 that I last saw him alive on 3-20-1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Tuberculous Peritonitis — Duration: 2-3 mos
Due to: 15
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings of operations: Tbc peritonitis c acites
Of autopsy: no

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: 0

23. Signature: D. A. Robertson (M. D. or other) MD
Address: Columbia Mo Date signed: 5/24/43

1200 (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 Strar D. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia Mo

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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13668

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 88

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: Co. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether
In this community 5 yrs
years, months or days)

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 Lucile Young

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex 7

5. Color or race B

6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife —

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

7. Birth date of deceased Jan 11 — 1913
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
30	2	10	hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace
(City, town, or county) (State or foreign country)

MOTHER
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

19. (a) 4-2-1947 (Date received local registrar) (b) Edna H. Barber (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 h 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)

(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 (M. D. or other)

Address Date signed