

S. No. 2
M-2-43
5-17-39
I X35897

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13815**

LED MAY 3 1943

Registration District No. **42**

Primary Registration District No. **6003**

Registrar's No. **428**

1. PLACE OF DEATH:

(a) County **Buchanan**

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

(c) Name of hospital or institution: **1109 Lincoln St**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **40 Years**
(Specify whether years, months or days)

In this community **40 Years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **1109 Lincoln St.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **David Riley Young**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **17**
year **1943** hour **2** minute **20 A**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary A Young**

6. (c) Age of husband or wife if alive **1856** years

7. Birth date of deceased **April 12** (Month) **1856** (Day) (Year)

21. I hereby certify that I attended the deceased from **April 1st** to **April 14**, 19**43**
that I last saw him alive on **April 14**, 19**43**
and that death occurred on the date and hour stated above.

8. AGE: Years **87** Months **0** Days **5** If less than one day **hr. min.**

Immediate cause of death **Thrombosis coronary arteries**

Due to **Arterio Sclerosis**

Due to **Arterio Sclerosis**

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

10. Usual occupation **Farmer**

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

11. Industry or business

12. Name **Christopher Young**

13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Polly Ann**

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

Major findings: Of operations **B/A**

Of autopsy

PHYSICIAN **Don't Know**

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mary A. Young**

(b) Address **St Joseph, Mo.**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof **4-19-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt Mora Cemetery**

18. (a) Signature of funeral director **Fleeman & Son Inc.**

(b) Address **1946 Colhoun St.**

19. (a) **4-19-43** (Date received local registrar)

(b) **Rose Stegoy** (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) (a) Means of Injury

23. Signature **Albert C. Holley** (M. D.)

Address **822 Edmond St.** Date signed **4/17/43**

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

MOTHER FATHER

1235

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 Robert H. Yaph
Licensed Embalmer No. 3308
P. O. Address St Joseph, 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.