

No. 2  
1-4-41  
5-17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20918

FILED JUN 29 1943

Registration District No. 42

Primary Registration District No. 100-1000

State File No. \_\_\_\_\_

Registrar's No. 669

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: State Mental Hospital - 2-2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7/20/43 to 6/20/43  
(Specify whether  
In this community 2 months  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County De Kalb  
(c) City or town Maysville (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6/20/43  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 4:50 A.M.  
21. I hereby certify that I attended the deceased from April 20th 1943 to June 20 1943  
that I last saw h. no alive on June 19 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Due to Myocarditis  
Due to Septic - Cerebral Arterio Sclerosis  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Duration 2da  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings: Of operations 93e1  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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. Buchanan MD (M.D. or other)  
Address State Hospital #2 Date signed 6/27/43

3. (a) PRINT FULL NAME Richard - Young

3. (b) If veteran, name war no 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Norma Huston Young 6. (c) Age of husband or wife if alive 16 years (Day) (Year)

7. Birth date of deceased 9/16/1875 (Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William H Young  
13. Birthplace Minnesota (City, town, or county) (State or foreign country)  
14. Maiden name Alice Finson  
15. Birthplace Minnesota (City, town, or county) (State or foreign country)

16. (a) Informant Hospital records  
(b) Address State Hospital

17. (a) REMOVED (b) Date thereof 6-23-43 (Month) (Day) (Year)

(c) Place: burial or cremation NOT PRESENT

18. (a) Signature of funeral director W. Buchanan  
(b) Address MAYSVILLE MO

19. (a) 6-22-43 (b) Rose Argoz (Registral's signature)  
(Date received local registrar)

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

*Robert  
(Barrett) Linn...  
1960*

*at 11:30 AM  
at 11:30 AM*

*1/27/60*

**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: *[Signature]*  
Licensed Embalmer No. *3960*  
P. O. Address: *Maryville 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.**