

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Suggitt
State File No. **1678**
Registrar's No. **299**

Registration District No. **38**

Primary Registration District No. **3006**

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:
503 Locust St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 Years** (Specify whether years, months or days)
In this community **15 Years**

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. **503 Locust St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **?**

3. (a) PRINT FULL NAME **MARY GRAUM YOUNG**

3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (c) Age of husband or wife if alive **1853** years
7. Birth date of deceased **5 - 4 - 1853**
(Month) (Day) (Year)

8. AGE: Years **91** Months **6** Days **29** If less than one day hr. min.

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

MOTHER FATHER {
12. Name **Amos Martin S**
13. Birthplace **Vermont**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah Williams**
15. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Patient (Mary young)**
(b) Address
17. (a) **Burial** (b) Date thereof **12-5-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Columbia Cemetery**

18. (a) Signature of funeral director **Harvey Funeral Service**
(b) Address **Columbia, Mo.**

19. (a) **12-8-1944** (b) **Edna H. Barber**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **3** year **1944** hour **11** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Nov-21** 1944, to **Dec-3** 1944 that I last saw her alive on **Nov-21** 1944 and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis**
Due to **93**
Due to
Other conditions (Include pregnancy within 3 months of death)

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

Major findings: Of operations **none**
Of autopsy **none**
23. Signature **J. C. Suggitt** (M. D. or other) **M.D.**
Address **Columbia, Mo.** Date signed **12-4-44**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

12 50

RECEIVED

District Health Officer No. 9¹/₂

District File Number.....

Date Filed 1-19-45

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 M. D. Whitcomb

Licensed Embalmer No. 3893

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.