

FILED JUL 29 1946

Registration District No. 46

Primary Registration District No. 4065

1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town Palo
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether)
In this community all his life years, months or days

3. (a) PRINT FULL NAME Rodger Franklin Youngblood

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M.D 5. Color or race wh 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: Feb. 14 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 3 19 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Woodrow Youngblood
13. Birthplace Ray Co. Mo
14. Maiden name Kathryn Cox
15. Birthplace Caldwell Mo

16. (a) Informant Woodrow Youngblood
(b) Address Palo

17. (a) Burial (b) Date thereof 6-5-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director W. J. ...

(b) Address Palo Mo

19. (a) June 6/46 (b) Gladys Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell
(c) City or town Palo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) D

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 3 day _____
year 1946 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from June 3 1946, to June 3 1946.

that I last saw him alive on June 3 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration 2 hrs

Due to Congenital Patent foramen Ovale 1 year

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 C.H. Wilson M.D. (M.D. or other)

Address Palo Mo Date signed 6-4-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

COON

SL 100

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, fact should be so stated above.