

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8705

8705

982

BIRTH NO. 49-028893 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 2 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 1421 Pleasant View Court	
3. NAME OF DECEASED (Type or Print) a. (First) Harmon		b. (Middle) Gunter	
c. (Last) Young II		4. DATE OF DEATH (Month) (Day) (Year) March 21, 1949	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Feb. 27, 1949
9. AGE (In years last birthday)		10. MONTHS	11. HOURS
2		2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX		10b. KIND OF BUSINESS OR INDUSTRY XX	
11. BIRTHPLACE (State or foreign country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Robert L. Young		13b. MOTHER'S MAIDEN NAME Elizabeth N.	
14. NAME OF HUSBAND OR WIFE XX		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) XX	
16. SOCIAL SECURITY NO. XX		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert L. Young 1421 Pleasant View Ct.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Stelectasis ANTECEDENT CAUSES DUE TO (b) Non-Viable Immature DUE TO (c) Pernatality II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 7625	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 27, 1949 , to 3-1, 1949 , that I last saw the deceased alive on March, 1949 , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Jacob P. Farney M.D.		23b. ADDRESS 6305 Brookside Pl	
23c. DATE SIGNED 3-2-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 2, 1949	
24c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		24d. LOCATION (City, town, or county) (State) Jackson County Missouri	
DATE REC'D BY LOCAL REG. 3-2-49		REGISTRAR'S SIGNATURE Sheldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE BENTLEY MORTUARY		ADDRESS 5811 Troost	

(Licensed Embalmer's Statement on Reverse Side)

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

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_____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.