

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37558**

FILED NOV 18 1952

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4014 Registrar's No. 88

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

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairfax		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Templeton Twsp) 0031	
c. LENGTH OF STAY (in this place) 2 da.		d. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Fairfax Community Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) Rosabelle	b. (Middle) B.	c. (Last) Young	4. DATE OF DEATH (Month) (Day) (Year) 11-7-1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single A	8. DATE OF BIRTH 3-8-1886	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR 7 Months	IF UNDER 2 YEARS 29 Days	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (State or foreign country) Atchison Co. Mo., U	12. CITIZEN OF WHAT COUNTRY? Am
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13a. FATHER'S NAME John Young	13b. MOTHER'S MAIDEN NAME Anna Winters	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	(If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm. Young	ADDRESS Rock Port. Mo.,
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage				3 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		DUE TO (b) _____		
		DUE TO (c) Arterio sclerosis		2 yrs.
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 11/4/, 52, to 11/7/, 1952, that I last saw the deceased alive on 11/6/, 1952, and that death occurred at 6 A.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS Rockport, Mo.	23c. DATE SIGNED 11/8/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-9-1952	24c. NAME OF CEMETERY OR CREMATORY Millsap Cem.	24d. LOCATION (City, town, or county) (State) Rock Port. Mo.,
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DATE REC'D BY LOCAL REG Nov 15 1952	REGISTRAR'S SIGNATURE [Signature] 443-0	25. FUNERAL DIRECTOR'S SIGNATURE Bartholomew Mortuary, Rockport, Mo	ADDRESS
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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 Grady Barshatowski

Licensed Embalmer No. 3173

P. O. Address Rosic Park, Pa.

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.