

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036708

STATE FILE NUMBER

FILED OCT 29 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4770

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City Salem</u> <sup>0331</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V.A. Hospital</u>		Length of stay in lb <u>2 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>9th and Tracy</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>J.</u> Last <u>YOUNG</u>			4. DATE OF DEATH Month <u>10th</u> Day <u>8th</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-30-95</u>	9. AGE (In years, <sup>or less</sup> <sub>months</sub> <sub>days</sub> ) <u>63 yrs</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Salem, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Samuel B. Young</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Carver</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>	16. SOCIAL SECURITY NO. <u>497 03 8194</u>	17. INFORMANT <u>V.A. Hospital Records, K.C., Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL CONFLUENCE BRONCHO PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ABDOMINAL CARCINOMATOSIS</u>	19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
	DUE TO (c) <u>PREVIOUSLY IRRADIATED CARCINOMA OF ESOPHAGUS; CARCINOMA OF PROSTATE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>7:05a</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u>	COUNTY	STATE
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21. <input checked="" type="checkbox"/> attended the deceased from <u>September 12, 1958</u> to <u>October 8, 1958</u> and the time of death was <u>7:05a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>A. J. Williams</u>	(Degree or title) <u>MD</u>	22b. ADDRESS <u>V.A. Hospital, Kansas City, Mo</u>	22c. DATE SIGNED <u>10-8-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Oct. 9, 1958</u>	23c. NAME OF CEMETERY, OR CREMATOR <u>MISSOURI NATIONAL CEMETERY JEFFERSON BARRACKS</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS - KANSAS CITY, MO</u>	ADDRESS <u>1331 BRUSH CREEK</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 .....  
Signature of Student Embalmer

Signed *Raymond M. Hardy*  
Licensed Embalmer No. *4913*  
P. O. Address *Indep. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.