Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001582
STATE FILE NUMBER 157

FILED JAN 21 1959

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

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Marys Hosp — Length of stay in Hospital 17 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 11965 E. 44th — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JOHN Middle F Last YOUNG
4. DATE OF DEATH Month 1 Day 8 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 12 12 1892
9. AGE (In years on last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Brakeman
10b. KIND OF BUSINESS OR INDUSTRY U.Pacific R. R
11. BIRTHPLACE (City and state or country) Holton, Kansas
12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME Samuel Young
13b. MOTHER'S MAIDEN NAME Victoria Dillinger
14. NAME OF HUSBAND OR WIFE Anna Margaret Young
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X X X
16. SOCIAL SECURITY NO. 509 01 7464
17. INFORMANT Mrs. Anna M. Young Address 11965 E. 44th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on a line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) cerebral arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-20-58, to 1-8-59 and last saw her/him alive on 1-8-59
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Graham Owens M.D. (Degree or title)
22b. ADDRESS 906 Grand KCMo
22c. DATE SIGNED 1-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-10-1959
23c. NAME OF CEMETERY OR CREMATORY Floral Hills
23d. LOCATION (City, town, or county) Kansas City (State) Missouri

24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc ADDRESS
25. DATE RECD. BY LOCAL REG. 1-9-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Graham Owens

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 John R. Sidno

Licensed Embalmer No. 4531

P. O. Address Kansas C

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.