

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-040897
STATE FILE NUMBER

FILED VS NOV 23 1959

Registration District No. 184 Primary Registration District No. 5692 Registrar's No. 125

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARSON CREEK TOP</u> <u>FOUNTAIN GROVE</u>		c. CITY OR TOWN <u>FOUNTAIN GROVE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1</u>		Length of stay in lb <u>50 YRS</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>HEROY</u> Last <u>YOUNGS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>59</u>	
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"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-19-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	9. AGE (In years last birthday) <u>78</u>
11. BIRTHPLACE (City and state or country) <u>WILLIAMSFIELD, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>FRANK L. YOUNGS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY JANE GALPIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>SARAH YOUNGS</u>		Address <u>FOUNTAIN GROVE, Mo.</u>	
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>Chronic myocarditis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinson's disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	
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 <u>1952</u> to <u>Nov 13-59</u> and last saw him alive on <u>Nov. 4, 1959</u> . Death occurred at <u>4:00</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Josiah F. Gale M.D.</u>		22b. ADDRESS <u>6 Gillicuddy Mo</u>	
22c. DATE SIGNED <u>11-14-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-15-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADVILLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MEADVILLE, MISSOURI</u>	
24. FUNERAL DIRECTOR <u>BROTHERS, MEADVILLE, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-14-59</u>	
26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Dep</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.
This certificate is to be completed in the proper manner required by 193.140 MoRS 1949. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.

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 *M. R. Wright*

Licensed Embalmer No. *4655*
P. O. Address *Meadville, 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.