

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021733

FILED VS. MAY 1 8 1960

318 Primary Registration District No. **1003** Registrar's No. **4775**

STATE FILE NUMBER

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Francois | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in lb 28 | | c. CITY OR TOWN LEADWOOD | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND AVE. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) P.O. BOX 315 | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROMIE A. YOUNT | | | | 4. DATE OF DEATH Month Day Year 5/4/60 | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 10/25/91 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) QUAKER, MISSOURI | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME WILLIAM YOUNT | | | 13b. MOTHER'S MAIDEN NAME MARY C. KING | | 14. NAME OF HUSBAND OR WIFE LOTTIE YOUNT | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES | | 16. SOCIAL SECURITY NO. NW-1 493-03-9753 | | 17. INFORMANT Address LOTTIE YOUNT, WIDOW, P.O. BOX 315 MO. LEADWOOD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) PULMONARY ABSCESS, RIGHT UPPER LOBE | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO (b) | | | | | | | | |
| DUE TO (c) 521x | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) EXTENSIVE MYOCARDIAL INFARCTION, OLD | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 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 a.m. p.m. Month, Day, Year | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 | | COUNTY | STATE | |
| 21. Attended the deceased from VA 4/6/60 | | to 5/4/60 | | and last saw him alive on 5/4/60 | | Death occurred at 12:05 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE (Degree or title) Richard S. Schoen M.D. | | | | 22b. ADDRESS VAH, ST. LOUIS, MO. | | 22c. DATE SIGNED 5/4/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 5-5-60 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) Leadwood, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Boyer Funeral Home, Leadwood, Mo. | | | 25. DATE RECD. BY LOCAL REG. MAY 5 1960 | | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 24 1969

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence Kahl

Licensed Embalmer No. 4596
P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.