MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17493

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis, Mo (No. City Hospital #2 St. ..... Ward)

File No. .....

Registered No. 4566.

2. FULL NAME George Young

(a) Residence. No. 3413 Clark St., 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	Col.	Wid.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-12-1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	64	2	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Eliza Dotson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. FILED ....., 19.. Max C. Harvey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-3-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-30-, 1930, to 5-3-, 1930 that I last saw him alive on 5-3-, 1930 and that death occurred, on the date stated above, at 2:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

93C

82A (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Chronic myocarditis

(duration) — yrs. 6 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A. E. Hale, M. D.

5/3/, 1930 (Address) City Hospital #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Washington Park	5-9- 1930

20. UNDERTAKER	ADDRESS
Gates Funeral Home	4127 Finney

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.