

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

26818

State File No. 6714

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME WALTER CLARENCE YOUNG 520

8. (b) If veteran, name war No. 8. (c) Social Security No. Unknown

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Carric Young 6. (c) Age of husband or wife if alive 38 years
 7. Birth date of deceased Feb. 22 1910
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>5</u>	<u>14</u>	hr. min.

9. Birthplace E. St. Louis, Ill.
 (City, town, or county) (State or foreign country)

10. Usual occupation Locomotive fireman

11. Industry or business

MOTHER FATHER
 { 12. Name Benjamin Young
 { 13. Birthplace Centralia, Ill.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Schellenberg
 { 15. Birthplace Highland, Ill. (rural)
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arthur Young
 (b) Address Highland, Ill.
 17. (a) Removal (b) Date thereof 8-7-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Stonington, Ill.

18. (a) Signature of funeral director Albert J. Hoppe
 (b) Address 4700 Washington Ave.
 19. (a) AUG 7 1940 (b) J. F. Bredek
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
 (c) City or town Stonington NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
 year 1940 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from June 21, 1940, to August 5, 1940.
 that I last saw him alive on August 5, 1940.
 and that death occurred on the date and hour stated above.

Immediate cause of death Monocytic Leukemia
 Due to _____
 Due to _____

Other conditions Ischemic Ulcers
 (Include pregnancy within 3 months of death)
due to staphylococcus
 Major findings:
 Of operations _____

Of autopsy Monocytic Leukemia
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature FR Bradley (M: D. or other)
 Address BARNES HOSPITAL Date signed _____

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *W. W. Wilkinson*.....
Licensed Embalmer No..... *3575*.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.