

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 5657

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. LOUIS CHILDREN'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 DAYS
(Specify whether

In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County (21)

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1337 Cleary Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME YOUNG, ALBERT

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, divorced, Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 23 1937
(Month) (Day) (Year)

8. AGE: Years 6 Months 5 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Moody (City, town or county) Mo (State or foreign country)

10. Usual occupation _____

11. Industry or business Child Infant

MOTHER FATHER { 12. Name Mrs Young

13. Birthplace Fry Mill Ark (City, town, or county) (State or foreign country)

14. Maiden name Olessa Novelly

15. Birthplace Cotton Plant Ark (City, town, or county) (State or foreign country)

16. (a) Informant Olessa Young

(b) Address 1337 Cleary

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-26-44
(Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PR. CEM

18. (a) Signature of funeral director A.F. WALTON

(b) Address 2707 STODDARD ST

19. (a) JUN 23 1944 (Date received local registrar) J. B. Bredish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 22 year 44 hour 1 minute 05 AM.

21. I hereby certify that I attended the deceased from 6-16-44 to 6-22-44
that I last saw him alive on 6-22-44 and that death occurred on the date and hour stated above.

Immediate cause of death Brain Tumor

Due to No malignancy

Due to _____

Other conditions (Include pregnancy within 3 months of death) 36

Major findings: Of operations _____ Of autopsy Brain Tumor

Duration

PHYSICIAN

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) (c) Means of Injury _____

23. Signature E. Smolicz (M. D. or other) _____
Address Walden Hospital St. L. Date signed 6/24/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. Claude Gordon*.....

Licensed Embalmer No.: *9489*.....

P. O. Address: *4575 Aldine*.....

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, fact should be so stated above.