

V. S. No. 2
100M-543
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 925
Registrar's No. 738

FILED JAN 31 1945 318
Registration District No. _____

Primary Registration District No. 100

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

20
17
9

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME Elvera Yount

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alfred Yount

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased April 10 1911
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>33</u>	<u>9</u>	<u>13</u>	hr. <u>1</u> min.

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name George L. Bettner

{ 13. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred Yount

(b) Address 9405 Upland Dr.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-24-45
(Month) (Day) (Year)

(c) Place: burial or cremation Cincinnati, Ohio

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 24 1945 (Date filed and recorded) (b) J. F. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 9405 Upland Dr.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23 year 1945 hour 11:00 minute 7 P. M.

21. I hereby certify that I attended the deceased from January 19, 1945 to 1-23-1945 and that death occurred on the date and hour stated above.

that I last saw her alive on 1-23-1945

Immediate cause of death Gangrene Rt. Foot

Due to Vegetative Bacterial Endocarditis?

Due to Rheumatic Heart

Other conditions Renal Infarcts
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Splenomegaly

Of operations _____

Of autopsy See Above

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) None

(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 Nicholas Vitale (M-D. or other) MD

Address 3861 St. Louis Ave. Date signed 1/23/45

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. Wilkison
..... Licensed Embalmer No..... *35-75*

..... 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, fact should be so stated above.