

**FILED** JAN 11 1946  
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County ~~Young~~ **Dorsey**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **City Infirmary** **0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **unknown** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Young, Doresey**

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

4. Sex **male** 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced, **Separated**

6. (b) Name of husband or wife **Bessie Thompson** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **May 10, 1883**  
(Month) (Day) (Year)

8. AGE: Years **62** Months **7** Days **10** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **unknown**

13. Birthplace **"** (City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **"** (City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmary Records**

(b) Address **5800 Arsenal St.**

17. (a) **Anatomical Board** Date thereof **12-25-45** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director **J. F. Bredek**

(b) Address **5300 Ritz**

19. (a) **DEC 28 1945** (Date received local registrar) **J. F. Bredek** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **421**  
(d) Street No. **802 N. Jefferson** (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **20th** year **1945** hour **12:00** minute **00** M.

21. I hereby certify that I attended the deceased from **Oct. 24, 1945** to **Dec. 20, 1945** that I last saw him alive on **Dec. 20, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypertensive Heart disease with hemiplegia** 1941

Due to **Hypertensive encephalopathy** 1945 plus \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: **93** Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **James R. Boudich** (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK

MOTHER FATHER

**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 318

Primary Registration District No. 1003

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:  
  
(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 Darsey young  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 10, 1982  
(Month) (Day) (Year)

8. AGE: Years 62 Months 22 Days 20 If less than one day..... hr. .... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) JAN 17 1948 (Date received local registry) J. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Day..... year..... hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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).....

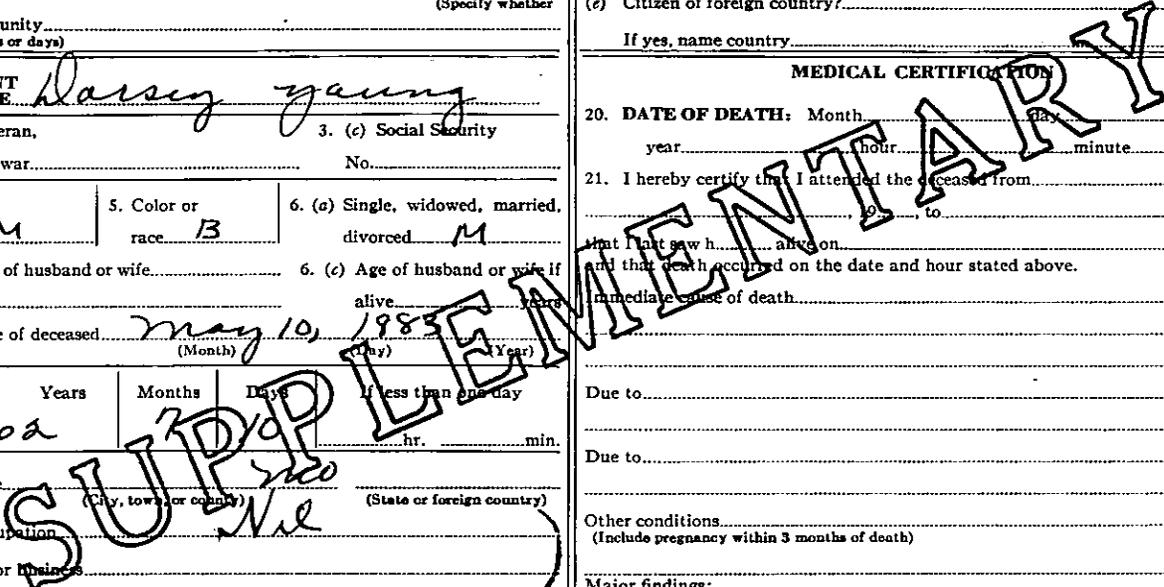
(b) Date of occurrence.....

(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..... (M. D. or other).....

Address..... Date signed.....



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

MOTHER FATHER,

39975