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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31560

FILED SEP 20 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7857

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 at 4228 S. Kingshighway
~~5003 Lindenwood Ave.~~
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

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

(d) Street No. 5003 Lindenwood Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME GRACE ANN YOUNT

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Dec. (Month) 13 (Day) 1899 (Year)

8. AGE: Years 48 Months 8 Days 23 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name William Hoffmann
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Hurst Yount
(b) Address 5003 Lindenwood Ave.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-8-48 (Month) (Day) (Year)
(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 S. Kingshighway Bl.

19. (a) SEP 7 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep't. day 6
year 1948 hour 10:00 ~~P.M.~~ minute A. M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Coronary Thrombosis;
CARCINOMA OF BREAST.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Alfred J. Perry (M. D. or other)
Address 1300 Clark Ave. Date signed 9-7-48

(Licensed Embalmer's Statement on Reverse Side)

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 Edwin S. McDermott

Licensed Embalmer No. 3024

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.

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7857

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
(5003 Lindenwood)
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

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

(d) Street No. 5003 Lindenwood
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Grace Ann Yount.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec - 13 - 1899
(Month) (Day) (Year)

8. AGE: 48 Years Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

OCT 6 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 6
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-31560