

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3184

State File No.

JAN 26 1950

104874

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **454**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St LOUIS		2 2 30	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1411 So. 10th St		23	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		3. NAME OF DECEASED a. (First) JAMES		b. (Middle) YOUNG	
c. (Last)		4. DATE OF DEATH Jan. 13th, 1950		(Month) (Day) (Year)	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Oct 3 1870	9. AGE (In years, Months, Days, Hours, Min.) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK
10a.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) UNK	12. CITIZEN OF WHAT COUNTRY? a		
13a. FATHER'S NAME UNK: YOUNG		13b. MOTHER'S MAIDEN NAME UNK		14. NAME OF HUSBAND OR WIFE UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. UNK		17. INFORMANT'S SIGNATURE OR NAME JAMES YOUNG	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) arteriosclerosis heart disease		10 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) Psychiatric seen to Central Nervous System		1 year?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4200	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/25/49 to 1/13/50, 19, that I last saw the deceased alive on 1/13/50, 19, and that death occurred at 2:55 pm m., from the causes and on the date stated above.					
23a. SIGNATURE W.S. Olney, M.D.		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 1/13/50	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-16-50		24c. NAME OF CEMETERY OR CREMATORY NEW ST MARCUS	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		24e. DATE REC'D BY LOCAL REG. JAN 16 1950		24f. REGISTRAR'S SIGNATURE	
24g. REGISTRAR'S SIGNATURE		24h. FUNERAL DIRECTOR'S SIGNATURE C.J. Schauer		24i. ADDRESS 3125 Lafayette	

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed: *Joseph B. Vollmer*

Licensed Embalmer No. *24014*

P. O. Address: *3125 Lafayette Ave*

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.