FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15145

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3815

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOMER G. PHILLIPS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2119
d. STREET ADDRESS (If rural, give location): 1928a North Taylor Ave 0

3. NAME OF DECEASED (Type or Print)
a. (First): Andrew
b. (Middle):
c. (Last): Young

4. DATE OF DEATH (Month) (Day) (Year): April 22 1950

5. SEX: male 2
6. COLOR OR RACE: col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 29 1895
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months 11, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry Work
10b. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): Tallieu La
12. CITIZEN OF WHAT COUNTRY?: U.S. A.

13a. FATHER'S NAME: Solomon Young
13b. MOTHER'S MAIDEN NAME: Martha ?
14. NAME OF HUSBAND OR WIFE: Lillian Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Lillian Young 1928A N. Taylor Avenue

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Myocarditis
DUE TO (c) decompensated

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4222

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 1100 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Dept. Com. 3
23b. ADDRESS: 1300 Clark Avenue
23c. DATE SIGNED: 4/24/50

24a. BURIAL, CREMATION, REMOVAL (Specify): 11
24b. DATE: April 27 1950
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis, County Missouri

DATE REC'D BY LOCAL REG.: APR 26 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.H.Randle & Son 3133 Bell Avenue

(Licensed Embalmer's Statement on Reverse Side)

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 S J Staton

Licensed Embalmer No. 2698

P. O. Address 2769 Chem

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.