

THE DIVISION OF HEALTH OF MISSOURI  
 FILED JUL 22 1950 STANDARD CERTIFICATE OF DEATH

 State File No. 25443  
 6088  
 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		State File No. 25443 6088					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) Life		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis							
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital				20 STREET ADDRESS (If rural, give location) 2702 Howard							
3. NAME OF DECEASED (Type or Print) Julia Young			a. (First)			b. (Middle)					
4. DATE OF DEATH July 12 1950			c. (Last)			5. DATE (Month) (Day) (Year)					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.		8. DATE OF BIRTH July 3, 1881					
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months 0		Days 9		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) Missouri					
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME ALBERT DAVIS		13b. MOTHER'S MAIDEN NAME SLINY BECKFORD		14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mrs Gertrude Fair			ADDRESS 1408 Glasgow			
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) Luetic Heart Disease with congestive Failure  ANTECEDENT CAUSES. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Syphilis  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH			
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) _____			
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? 023X							
22. I hereby certify that I attended the deceased from 7-10-1950, to 7-12-1950, that I last saw the deceased alive on 7-12-1950, and that death occurred at 4:10p. m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) _____ D.				23b. ADDRESS 2601 N Whittier St				23c. DATE SIGNED 7-14-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-19-50		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEM. ST. LOUIS		24d. LOCATION (City, town, or county) CTY. MO		(State) _____			
DATE REC'D BY LOCAL REG. JUL 15 1950		REGISTRAR'S SIGNATURE J. B. Sasser				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. F. WALTON 2707 STODDARD					

(Licensed Embalmer's Statement on Reverse Side)

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

1951  
64  
1886

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Arthur L. Hilliard*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4231*

P. O. Address *4049 St Jackson*

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.