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S. No. 300
V. 10.48

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35493**
Registrar's No. **9120**

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 35493		Registrar's No. 9120											
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) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			2199										
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 4328 Delmar															
3. NAME OF DECEASED (Type or Print) John		a. (First)		b. (Middle) Young		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Oct. 25 1950											
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Dec. 12, 1905		9. AGE (In years last birthday) 44		IF UNDER 1 YEAR Months Days 10		IF UNDER 11 HRS. Hours Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A									
13a. FATHER'S NAME Cordie Young				13b. MOTHER'S MAIDEN NAME Jennie Houston				14. NAME OF HUSBAND OR WIFE Single											
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 Andrew Young, Brother,		ADDRESS 4581 Cottage													
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Avitaminosis												MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Cholelithiasis						INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 28616															
22. I hereby certify that I attended the deceased from 10-21 , 19 50 , to 10-25 , 19 50 , that I last saw the deceased alive on 10-25 , 19 50 , and that death occurred at 7:15p m. , from the causes and on the date stated above.																			
23a. SIGNATURE Alvin J. Shoup				(Degree or title) _____				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 10-26-50									
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 10-30-50		24c. NAME OF CEMETERY OR CREMATORY Washington				24d. LOCATION (City, town, or county) (State) on north end bridge											
DATE REC'D BY LOCAL REG. OCT 27 1950		REGISTRAR'S SIGNATURE J. B. Laster				25. FUNERAL DIRECTOR'S SIGNATURE Sneek		ADDRESS 3615 Boston											

(Licensed Embalmer's Statement on Reverse Side)

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

0221 23

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.....
Student Embalmer

Signed.....

IS- 1 Licensed Embalmer No.....

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.