

FILED AUG 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25544**
7026

BIRTH NO. **55004-50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY 0		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 town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		2. STREET ADDRESS (If rural, give location) 2734 So. Jefferson 0	

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) _____ c. (Last) Young			4. DATE OF DEATH (Month) (Day) (Year) Aug. 4, 1951		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Sept. 1, 1950	9. AGE (In years last birthday) 11	IF UNDER 1 YEAR Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Charles Young	13b. MOTHER'S MAIDEN NAME Mary Govere	14. NAME OF HUSBAND OR WIFE None
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Charles Young, 2734 So. Jefferson ADDRESS _____
--	-------------------------------------	--

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		INTERVAL BETWEEN ONSET AND DEATH 7 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Marked Dehydration and Ptoemia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diarrhea of unknown cause. DUE TO (c) _____		
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 <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) 5710
--	--	---

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 **8/3**, 19**51**, to **8/4**, 19**51**, that I last saw the deceased alive on **8/4**, 19**51**, and that death occurred at **8:10p** m., from the causes and on the date stated above.

23a. SIGNATURE E. Williamson (Degree or title) _____	23b. ADDRESS 6336 Clayton Road	23c. DATE SIGNED 8/6/51
---	---------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-5-51	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Tiff. Mo.
--	-------------------------	--	--

DATE REC'D BY LOCAL REG. AUG 6 1951	REGISTRAR'S SIGNATURE Ja B Pasator	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd. ADDRESS _____
--	---	--

(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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed _____
Student Embalmer

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.