

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **14297**

No. 300
10.48

FILED APR 26 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3230**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1615 Mullamphy Str		2b. STREET ADDRESS (If rural, give location) 1615 Mullamohy str 2269	
3. NAME OF DECEASED (Type or Print) a. (First) Emily b. (Middle) Frances c. (Last) Young		4. DATE OF DEATH (Month) (Day) (Year) 4-9-54	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Dec 19-80
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (City and State or Foreign Country) St Louis, Mo
13a. FATHER'S NAME Fredrick Tiefenbrunn		13b. MOTHER'S MAIDEN NAME Margarett Siencor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT'S SIGNATURE OR NAME Walter Young		ADDRESS 1615 Mullamphy	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocarditis ANTECEDENT CAUSES Heart failure Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Chc nephritis Conditions contributing to the death but not related to the disease or condition causing death. acute leukemia	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Coronary sclerosis	
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) St Louis 410X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	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 Jan 9 1951 to 4 9 54 , that I last saw the deceased alive on 19 , and that death occurred at 1:30 PM from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 1895 Madison	
23c. DATE SIGNED 4 9 54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/12/54	24c. NAME OF CEMETERY OR CREMATORY St Peter & Paul	24d. LOCATION (City, town, or county) (State) St Louis Mo
DATE REC'D BY LOCAL REG. APR 10 1954		REGISTRAR'S SIGNATURE [Signature]	
53. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Central Funeral Home 1841 Cass	

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.....
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *37491*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.