

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY SAINT CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN E. ST. LOUIS 8/20 8	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL 0		d. STREET ADDRESS (If outside, give location) 32 1135 N. 43RD ST.	
3. NAME OF DECEASED (Type or print) First EARL Middle T. Last YOUNG		4. DATE OF DEATH Month Day Year NOVEMBER 4, 1957	
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) ILLINOIS
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) HYPERTENSIVE HEART DISEASE 420.1			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. Attended the deceased from 10/31/57 to 11/4/57 and last saw him alive on 11/4/57 Death occurred at 5:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dee or title) H. Westphaelinger 0		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 11/4/57			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/5/57	
23c. NAME OF CEMETERY OR CREMATORY F. WESTPFAELINGER, M.D. NATIONAL		23d. LOCATION (City, town, or county) (State) JEFFERSON BKS MO	
24. FUNERAL DIRECTOR Robins Funeral Home		25. DATE RECD. BY LOCAL REG. NOV 5 57	
ADDRESS 6 St Louis Ill		26. REGISTRAR'S SIGNATURE J. Paul Smith, M.D. J.P.	

8-105-1

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 *Frank Brown*

Licensed Embalmer No. *4313*  
P. O. Address *St Louis Mo*

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.