

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042454

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10915

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in 1b 2028	d. STREET ADDRESS (If outside, give location) 5405 Childress Av.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last ETHRON T. YOUNG			4. DATE OF DEATH Month Day Year Nov. 11 1958		
5. SEX Male <input type="radio"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1891		9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor-Southwestern Hearing Aid Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Wilson Co., Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Aaron T. Young		13b. MOTHER'S MAIDEN NAME Laura Belle Posey		14. NAME OF HUSBAND OR WIFE Zelma P. Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. 478-18-1560		17. INFORMANT Address Zelma P. Young 5405 Childress Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon with metastases</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <u>153.8</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>A.S.H.D.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 mos</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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. I attended the deceased from <u>Feb 1, 1957</u> to <u>Nov 11, 1958</u> and last saw ^{her} _{him} alive on <u>Nov 11, 1958</u> Death occurred at <u>9:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. Cecelia Reichert, M.D.</u>			22b. ADDRESS <u>539 N. Grand Blvd (3)</u>		22c. DATE SIGNED <u>11/13/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Nov. 14, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u>			25. DATE RECD. BY LOCAL REG. <u>NOV 13 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Edurn K G^c Acworth*

Licensed Embalmer No. *3024*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.