

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003664

STATE FILE NUMBER

2 930

FILED FEB 16 1959 Registration District No. Primary Registration District No. Registrar No.

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Pine Lawn 4151	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 3726 Manola Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE M. YOUNG		4. DATE OF DEATH Month Day Year JANUARY 27, 1959	
5. SEX Female	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 October 22, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Boone County, Mo.
13a. FATHER'S NAME John Dudley Moynihan		13b. MOTHER'S MAIDEN NAME Margaret Dye	14. NAME OF HUSBAND OR WIFE Late Walter R. Young
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mr. John H. Young, 225 N. Maramac 5
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>ADENOCARCINOMA OF SIGMOID COLON WITH METASTASES TO ABDOMINAL CAVITY, LIVER AND BRAIN</u>			INTERVAL BETWEEN ONSET AND DEATH 3-4 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 153.3			
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 checked="" type="checkbox"/>
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 WORK <input type="checkbox"/> NOT WHILE 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 JAN. 9, 1959 to JAN. 27, 1959 and last saw her/him alive on JAN. 27, 1959 Death occurred at 6:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Carl Smith M.D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/27/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/30/59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 NAT'L BRIDGE BLVD		25. DATE RECD. BY LOCAL REG. JAN 27 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith mfb.</i>

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 *John A. Merson*
Licensed Embalmer No. *4186*
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.