

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS OCT 28 1959

59-038245

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9628**

RECEIVED

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BY AFFIDAVIT OF Funeral Director

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1729a S. 9th</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>AMN</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>20</b> Year <b>1959</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>4-2-1903</b>		9. AGE (last birthday) <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>American Car &amp; Foundry</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Young</b>			13b. MOTHER'S MAIDEN NAME <b>Daisy Crabtree</b>			14. NAME OF HUSBAND OR WIFE <b>Celia Young</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Yes(Unk)</b>		17. INFORMANT Address <b>Charles Young, 1729a S. 9th</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b>							<b>5 MINUTES</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>CONGESTIVE HEART FAILURE</b>					<b>2 WEEKS</b>		
DUE TO (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>							<b>5 YEARS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>MESENTERIC ARTERIAL OCCLUSION</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <b>443 X</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ a.m. _____ p.m.		Month, Day, Year							
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 <b>OCT. 14, 1959</b> to <b>OCT. 20, 1959</b> and last saw him alive on <b>OCT. 20, 1959</b> Death occurred at <b>8:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>C. O. Vermillion, M.D.</i>				22b. ADDRESS <b>BARNES HOSPITAL</b>				22c. DATE SIGNED <b>10/20/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-23-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>			23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>			
24. FUNERAL DIRECTOR <b>McLaughlin, 2301 Lafayette, St. Louis, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 20 1959</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

**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

*James R. Chapman*

Licensed Embalmer No. 4532

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.