

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED SEP 12 1960

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2448

STATE FILE NUMBER -60-033433

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b <b>6 WEEKS</b>		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>GRAVOIS REST HOME</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4229a SHENANDOAH</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>FLOYD</b> Middle <b>B.</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>1960</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</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>1/12/1886</b>		9. AGE (last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>ACCOUNTANT</b>			11. BIRTHPLACE (City and state or country) <b>LYONS, NEW YORK</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>				
13a. FATHER'S NAME <b>DANIEL M. YOUNG</b>				13b. MOTHER'S MAIDEN NAME <b>AURALIA (LAST UNKNOWN)</b>				14. NAME OF HUSBAND OR WIFE <b>RUBY A. 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>497-01-7461</b>		17. INFORMANT Address <b>ST. LOUIS</b> <b>FRANK B. POLLARD, 6730 ARSENAL STREET</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate &amp; metastasis</b>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <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"/> <b>none</b>		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>7-1-60</b> to <b>8-15-60</b> and last saw <sup>her</sup> him alive on <b>8-10-60</b> Death occurred at <b>8-15-60 7:15 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Allen M. Kearney M.D.</b> (Degree or title)						22b. ADDRESS <b>4308 E. Peter St. Louis Co. 19, Mo.</b>				22c. DATE SIGNED <b>8-16-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>8/18/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KEMPER CEMETERY</b>				23d. LOCATION (City, town, or county) <b>KEMPER, ILLINOIS</b>					
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY</b> <b>6464 CHIPPEWA STREET ST. LOUIS, MISSOURI</b>						25. DATE RECD. BY LOCAL REG. <b>8-16-60</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill C. Dranso

Licensed Embalmer No. 476  
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.