ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027533
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6982

FILED AUG 8 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY St. Clair

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b 13 days

c. CITY OR TOWN E. St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) PEOPLES HOSPITAL — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1640 St. Louis Avenue — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Lillian Middle Last Younge

4. DATE OF DEATH Month July Day 25, Year 1961

5. SEX Female

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 9-12-1898

9. AGE (last birthday) 62 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY At home

11. BIRTHPLACE (City and state or country) Mayfield, Kentucky

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME —

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE Otto Younge, deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT Henry Young — Address 1640 St. Louis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH 5 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Diabetes Mellitus — 2 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Amputation Right Leg. (B.K)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 260X

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 5-6-59, to 7-25-61 and last saw her alive on 7-25-61
Death occurred at 7:50 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. A. Fingal M.D.

22b. ADDRESS 1652 Central Ave E St Louis, Ill.

22c. DATE SIGNED 7-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 7-27-61

23c. NAME OF CEMETERY OR CREMATORY B

23d. LOCATION (City, town, or county) (State) E. St. Louis, Illinois

24. FUNERAL DIRECTOR M. Francis Nash — ADDRESS NASH FUNERAL HOME, 111 North 13th St.

25. DATE RECD. BY LOCAL REG. JUL 27 1961

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

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 M. Frances Nash

Licensed Embalmer No. 4434

P. O. Address 111 N 13th

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.