

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-015762

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 69

FILED MAY 1 1962	
1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mountain View Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN <u>Herculaneum</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle _____ Last <u>YOUNG</u>	
4. DATE OF DEATH <u>4/23/1962</u> Month <u>4</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <u>5/24/69</u>	9. AGE (last birthday) <u>92</u>
IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>
11. BIRTHPLACE (City and state or country) <u>Riverside, Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Charles Brown Tilden</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>	
14. NAME OF HUSBAND OR WIFE <u>Fred Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>George Fischeissen</u> Address <u>St. Louis Mo.</u>	
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>Cerebral Hemorrhage</u> 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 checked="" 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 checked="" 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>6-19-61</u> to <u>4-23-62</u> and last saw her alive on <u>4-23-62</u> Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>R. D. Darnell, M.D.</u>	
22b. ADDRESS <u>Crystal City, Mo.</u>	
22c. DATE SIGNED <u>4-24-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>4/24/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
24. FUNERAL DIRECTOR <u>Lupton Chapel; 7233 Delmar Blvd</u> ADDRESS _____	
25. DATE RECD. BY LOCAL REG. <u>4/24/62</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

VS 300
Rev. 4/59
10500
205002
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4 1
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9331X
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1286-0
131-0

Subject

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

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.