

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35574

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 791
Primary Registration District No. 1003

File No. _____
Registered No. 10807
St. _____ Ward _____

2. FULL NAME John N. Young

(a) Residence No. 5124 Wells Ave St. 6 Ward _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Audrey Young

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25/1881

7. AGE Years 46 Months 11 Days 5 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Carpenter (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Grand (STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Henry N. Young

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mount Joy Pa. (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Susan Wesley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milton Grove Pa (STATE OR COUNTRY) _____

14. INFORMANT Mrs. Audrey Young (Address) 5124 Wells Ave

15. FILED Nov 21 Max C. Starkopf REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 29th 1927

17. I HEREBY CERTIFY That I attended deceased from 7th November 4th 1927, to November 29th 1927 that I last saw him alive on November 29th 1927, and that death occurred, on the date stated above, at 10:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Haemorrhage

34 82.5 (duration) yrs. mos. 25 da.

CONTRIBUTORY (SECONDARY) Cerebral Syphilis I don't know (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

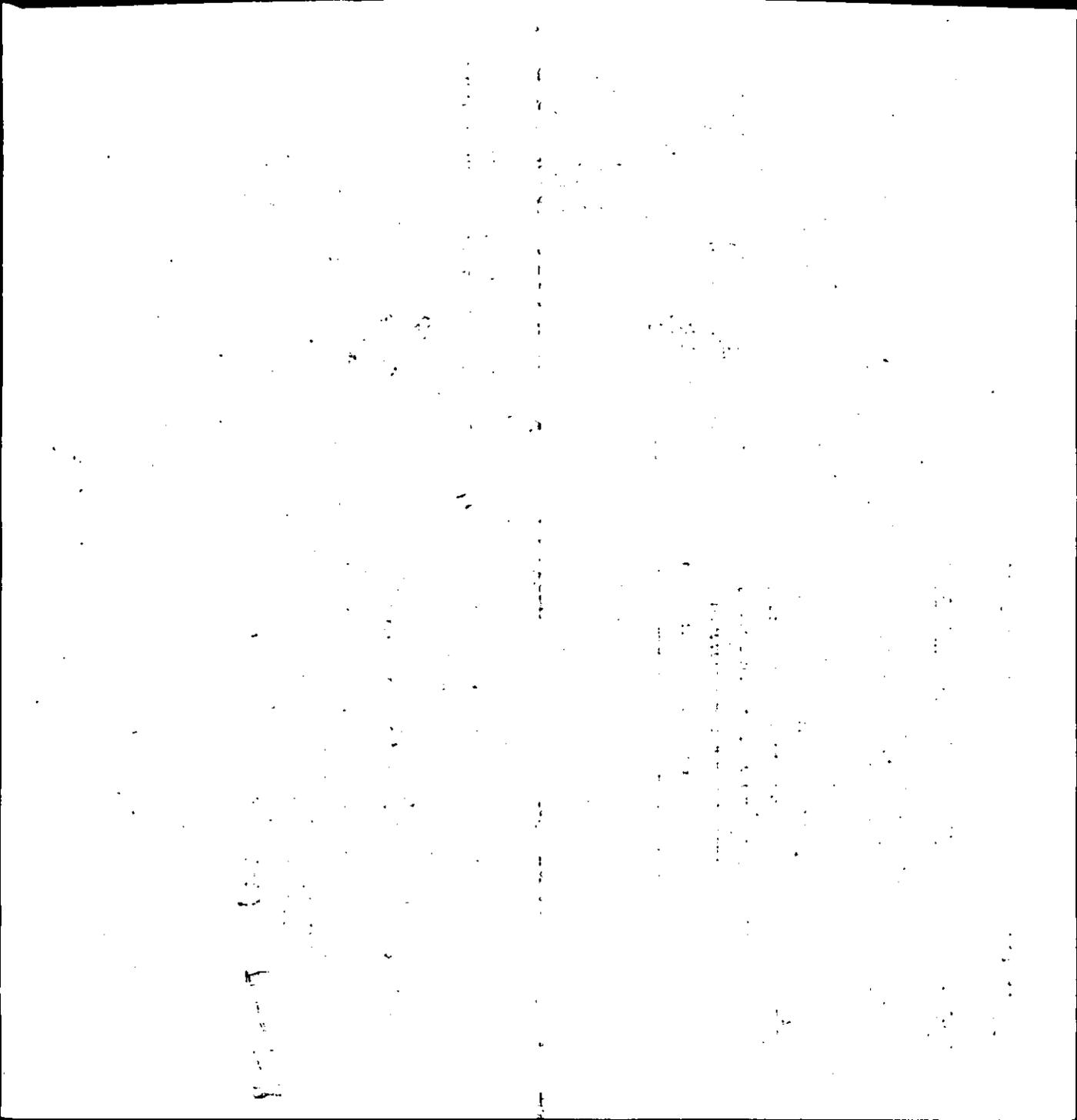
19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____ WAS THERE AN ALLOPATHY? No

WHAT TEST CONFIRMED DIAGNOSIS? Spinal puncture (Signed) Blood Wasserman J. F. Gallagher, M. D. 121, 1927 (Address) 311-3130 Wall Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL Dec 3 1927

20. UNDERTAKER Chas. L. Geraghty ADDRESS 4822 Eastern Ave



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 291 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 10807
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IN MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23 - 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 45 11 X 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. FILED 19 Mar 6 1890 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 19 27

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____, after on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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