

REC'D FEB 10 1939

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

790
Do not use this space.

791
1008

790

1. PLACE OF DEATH

- (a) County St. Louis Registration District No. 1008
- (b) Township St. Louis or City St. Louis Primary Registration District No. _____ Registered No. 790
- (c) City St. Louis (d) Street No. Sumner Dealey Hosp St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

- (a) Residence, No. 9512 Clyde St. NR LEMAP, MO
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>-</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>January 24, 1939</u>		
7. AGE YEARS	MONTHS	DAYS
		If LESS than 1 day, <u>14</u> hrs. or <u>40</u> min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	

12. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo (STATE OR COUNTRY) Mo

FATHER 13. NAME William Young

FATHER 14. BIRTHPLACE (CITY OR TOWN) Carbondale, Ill (STATE OR COUNTRY) Ill

MOTHER 15. MAIDEN NAME Lucille Barker

MOTHER 16. BIRTHPLACE (CITY OR TOWN) Knoxville, Tenn (STATE OR COUNTRY) Tenn

17. INFORMANT Mrs. Lucille Young (ADDRESS) 3848 Maple St. Louis, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope DATE 1-25 1939

19. FUNERAL DIRECTOR (NAME) Fender and Co. (ADDRESS) 7420 Michigan

20. FILED JAN 25 1939 J. B. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-24 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/24, 1939, to 1/24, 1939.
I last saw h. e. a. alive on 1/24, 1939. Death is said to have occurred on the date stated above, at 5:05 p.m.
The principal cause of death and related causes of importance were as follows:

Atelectasis Bilateral
Pneumonia left

Other contributory causes of importance:
159

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) S. A. Mitchell, M. D.
(Address) 1335 S. Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Not embalmed
CF

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No..... **701**
 (b) Township..... Primary Registration District No..... **1009**
 or
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **790**

2. PRINT FULL NAME

(a) Residence, No. **LUCILLE YOUNG**
3848 MAFFITT AVE St. **11** **ST LOUIS MO**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)			
7. AGE	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
	9. Industry or business in which work was done, as saw mill, bank, etc.		
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
FATHER	13. NAME		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
MOTHER	15. MAIDEN NAME		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)			
18. BURIAL, CREMATION, OR REMOVAL			
PLACE DATE 19			
19. FUNERAL DIRECTOR (NAME) (ADDRESS)			
20. FILED 2/17 19 39 J. B. Budick Local Registrar			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-24-39**

22. I HEREBY CERTIFY, That I attended deceased from 19....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify..... (Signed)....., M. D.
 (Address).....

N. B.—Every item of information should be carefully supplied. 'AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

SUPPLEMENTARY

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.