

REC'D MAR 13 1939

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

4402
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **1095**
(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.
D. 15726 **Baby Young**

2. PRINT FULL NAME

(a) Residence, No. **3634 Shenandoah St.** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city) **17**

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male**
4. COLOR OR RACE **white**
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1/27/39** 19

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

22. I HEREBY CERTIFY That I attended deceased from **1/27/39** 19 to **1/27/39** 19

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **January 27, 1939**

Last saw h. **him** **1/27/39** 19 Death is said to have occurred on the date stated above, at **31.20** m.p.
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 0 15 50

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. **infant**
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Date of onset
Premature
154

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

Other contributory causes of importance:

FATHER
13. NAME **Carl Young**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

MOTHER
15. MAIDEN NAME **Florence Marslla**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pennsylvania**

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **Memorial Park 2-3-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Cullinane Brothers 1710 N. Grand Blvd.**

20. FILED **FEB 3 1939** *J.F. Budeck* Local Registrar

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) *John F. Flynn*, M. D.
(Address) **City Hospital**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Not embalmed

(17)

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.