No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
#48680

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15816

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4532

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000 17

(c) City or town St Louis 119
(If outside city or town limits, write "RURAL")

(d) Street No. 1901 N. Grand
Memorial (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME SHIRLEY ANN YOUNG

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, ~~widowed~~, ~~married~~, divorced 0

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 4 (Month) 11 (Day) 1947 (Year)

8. AGE: Years | Months | Days 16 | If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country) 1

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Roscoe Edward Young
13. Birthplace Alton Ill (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Della Young 0
15. Birthplace St Louis, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Della Young
(b) Address 1901 No Grand Ave

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 5-5-47 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Lake Charles -

18. (a) Signature of funeral director Chas. A Burk
(b) Address 445 V Washington Blvd

19. (a) MAY 5 1947 (Date received local registrar) (b) J. F. Breseck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th year 1947 hour 3:55 minute P M.

21. I hereby certify that I attended the deceased from 4/20/47, 19..., to 4/27/47, 19...; that I last saw her alive on 4/27/47, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Adrenal Insufficiency ??

Due to Epidemic Diarrhea of the Newborn, (which had stopped)

Due to

Other conditions (Include pregnancy within 3 months of death) 119

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? 8 V Gallatin (Means of injury) D

23. Signature 1515 Lafayette (M. D.) 4/28/47

Address Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Not embalmed

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.