

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22165

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5506**

1. PLACE OF DEATH
a. COUNTY **MISSOURI**

b. CITY (If outside corporate limits, write RURAL and give township) **ST. LOUIS**
c. LENGTH OF STAY (In this place) **10. DAY**
c. CITY (If outside corporate limits, write RURAL and give township) **ST. LOUIS**
OR TOWN **2119**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Homer G Phillips Hospital**
d. STREET ADDRESS (If rural, give location) **1703 N. TAYLOR**

3. NAME OF DECEASED
a. (First) **Cornelia** b. (Middle) **Young** c. (Last) **Young**
4. DATE OF DEATH (Month) (Day) (Year) **June 22 1950**

5. SEX **FEMALE** 6. COLOR OR RACE **NEGRO** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWED** 8. DATE OF BIRTH **6-12-1896** 9. AGE (In years) last birth (Month) (Day) (Year) **53**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOUSEWIFE** 10b. KIND OF BUSINESS OR INDUSTRY **NONE** 11. BIRTHPLACE (State or foreign country) **TENN** 12. CITIZEN OF WHAT COUNTRY? **YES**

13a. FATHER'S NAME **HENRY JARRETT** 13b. MOTHER'S MAIDEN NAME **WYNNE** 14. NAME OF HUSBAND OR WIFE **CHARLIE YOUNG**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT'S SIGNATURE OR NAME **Hazel Hawkins** ADDRESS **1703 N. Taylor**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Lympho-sarcoma**
INTERVAL BETWEEN ONSET AND DEATH **Undet.**
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:
DUE TO (b) **Undetermined**
DUE TO (c) **None**
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **None**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **2001**

22. I hereby certify that I attended the deceased from **6-13**, 19**50**, to **6-22**, 19**50**, that I last saw the deceased alive on **6-22**, 19**50** and that death occurred at **6:35 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE **Oliver J. Thompson** (Degree or title) 23b. ADDRESS **2601 N Whittier** 23c. DATE SIGNED **6-23-50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24b. DATE **6/26/50** 24c. NAME OF CEMETERY OR CREMATORY **WASHINGTON PARK Cem.** 24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. **JUN 25 1950** REGISTRAR'S SIGNATURE **J. B. Casater** 25. FUNERAL DIRECTOR'S SIGNATURE **Jake Jones** ADDRESS **1343 N. Howell St. Land, Mo.**

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Arthur L. Halliard

Signed.....

Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4049 St Ferdinand*

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, fact should be so stated above.