

FILED SEP 9 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 28827
 Registrar's No. 7300

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY 3443 Laclede Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2219					
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 20 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 3443 Laclede Ave.			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3443 Laclede Ave				d. STREET ADDRESS (If rural, give location) 3443 Laclede Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Josephine			b. (Middle) _____		c. (Last) York		4. DATE OF DEATH (Month) (Day) (Year) Aug 24, 1950		
5. SEX F		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) separated		8. DATE OF BIRTH Feb 15, 1893			
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Miss. 1			
11. BIRTHPLACE (State or foreign country) Miss. 1		12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Jimmie Dikshimon		13b. MOTHER'S MAIDEN NAME Francis Salton			
13a. FATHER'S NAME Jimmie Dikshimon		13b. MOTHER'S MAIDEN NAME Francis Salton		14. NAME OF HUSBAND OR WIFE Grantor York		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 499-01-0258		17. INFORMANT'S SIGNATURE OR NAME Ettrude Buchanan		ADDRESS 1337 Market			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy				ANTECEDENT CAUSES Hypertension				1 day	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____				DUE TO (c) _____				1 yr	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				_____				_____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		_____			
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 OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 224X		_____			
22. I hereby certify that I attended the deceased from Jan 1, 1950 , to Aug 21, 1950 , that I last saw the deceased alive on Aug 24, 1950 , and that death occurred at 8:40 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE W. W. Young				23b. ADDRESS D. 2337 Market		23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 8-29-50		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. AUG 28 1950		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE Joseph Berry		ADDRESS 2811 1/2 Clark			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 1441

P. O. Address 2859 Washington

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.