

FILED MAR 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10825
2257

State File No. _____
Registrar's No. _____

318 1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
c. LENGTH OF STAY (In this place) 8 days		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST MARYS INFIRMARY		d. STREET ADDRESS (If rural, give location) 4748 ST LOUIS AVE	

3. NAME OF DECEASED (Type or Print) MRS HATTIE YOUNG			4. DATE OF DEATH MARCH 11 1951		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH MAY 15, 1887	9. AGE (In years last birthday) 63	If UNDER 1 YEAR Months 9 Days 24	If UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) James Youngstown, Ohio U.S.A	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME THOMAS WILLIS	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE JOHN YOUNG
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mable James	ADDRESS 4748 St Louis
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Dis.		
	DUE TO (c)		
	11. 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 checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X
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22. I hereby certify that I attended the deceased from **Mar. 5, 1951**, to **Mar. 11, 1951**, that I last saw the deceased alive on **Mar. 10, 1951**, and that death occurred at **12:05 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James M. Whittier M.D.	23b. ADDRESS 4503 N. Page	23c. DATE SIGNED 3-12-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 3-15-1951	24c. NAME OF CEMETERY OR CREMATORY WABBESEKA	24d. LOCATION (City, town, or county) (State) ARK.
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DATE RECEIVED BY LOCAL HEALTH DEPT. OR REG.	REGISTRAR'S SIGNATURE J. B. Lanster	25. FUNERAL DIRECTOR'S SIGNATURE Bennie Lane	ADDRESS 3103 Washington
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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 H. Claude Gordon

Signed.....
Student Embalmer

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.