

FILED MAY 17 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18774  
18775  
State File No. 4404

BIRTH NO.		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. <b>4404</b>
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>7122 Rabenberg Pl.</b>		e. STREET ADDRESS (If rural, give location) <b>7122 Rabenberg Pl.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>LOUISE</b>		b. (Middle) <b>E</b>		c. (Last) <b>Young</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>5-9-51</b>		5. SEX <b>Female</b>		
6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>4-18-1881</b>
9. AGE (In years last birthday) <b>70</b>		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Frederick Wm. Linkelmann</b>
13b. MOTHER'S MAIDEN NAME <b>Clara Block</b>		14. NAME OF HUSBAND OR WIFE <b>Lee Young</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Elsie Lee Das</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>General Carcinomatosis</b> ANTECEDENT CAUSES (b) <b>Carcinoma of breast</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>170X</b>
22. I hereby certify that I attended the deceased from <b>4-30, 1951</b> , to <b>5-8, 1951</b> , that I last saw the deceased alive on <b>5-8, 1951</b> , and that death occurred at <b>7:10 a.m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE <b>A. Sterling M.D.</b> (Degree or title)		23b. ADDRESS <b>7266 Manchester</b>		23c. DATE SIGNED <b>5-9-51</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-11-1951</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		DATE REC'D BY LOCAL REG. <b>J. B. Pasater</b> REGISTRAR'S SIGNATURE		
25. FUNERAL DIRECTOR'S SIGNATURE <b>JAY B. SMITH</b>		ADDRESS <b>Maplewood 17, Mo.</b>		

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

MAY 10 1951

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 \_\_\_\_\_

*J.P. Burgess*

Licensed Embalmer No. \_\_\_\_\_

4029

P. O. Address \_\_\_\_\_

*Maplewood*

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.