

1550 NOV 12 1952

STANDARD CERTIFICATE OF DEATH

State File No. **37034**
9564

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

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE **Mo.** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) **St. Louis**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis** **2079**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Mo Pacific Hospital**

d. STREET ADDRESS (If rural, give location) **+751 Thrush**

3. NAME OF DECEASED
a. (First) **John** b. (Middle) **Hyatt** c. (Last) **Young**

4. DATE OF DEATH (Month) (Day) (Year)
10-16-52

5. SEX **M**

6. COLOR OR RACE **W**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED
Married

8. DATE OF BIRTH **3/14/76**

9. AGE (In years last birthday) **76**

10. IF UNDER 1 YEAR (Month) (Day) (Hour) (Min.)
76

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chemist, freight

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
Holden Mo

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME
George Young

13b. MOTHER'S MAIDEN NAME
Estell Hyatt

14. NAME OF HUSBAND OR WIFE
Jane Young

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.
none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Jane Young, 751 Thrush

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) **Chr. Myocardial Failure**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Senility**
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or conditions causing death.

INTERVAL BETWEEN ONSET AND DEATH
2 yrs

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 OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR
4222

22. I hereby certify that I attended the deceased from 9/22, 1952 to 10/16, 1952, that I last saw the deceased alive on 10/16, 1952, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
[Signature]

23b. ADDRESS
[Address]

23c. DATE SIGNED
10-16-52

24a. BURIAL, CREMATION REMOVAL (Specify)

24b. DATE
10-18-52

24c. NAME OF CEMETERY OR CREMATORY
Holden

24d. LOCATION (City, town, or county) (State)
Holden Mo

DATE REC'D BY LOCAL REG.
OCT 17 1952

REGISTRAR'S SIGNATURE
[Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
[Signature] **Harrod 1905 Union**

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 *Abner P. Thompson Jr*

Licensed Embalmer No. *4237*

P. O. Address _____

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.