

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27064

48434  
FILED JUL 31 1953

State File No. \_\_\_\_\_  
Registrar's No. 6628

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN East St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		e. STREET ADDRESS (If rural, give location) 1016 No. 47th St. 8120 8	
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) ----- c. (Last) York		4. DATE OF DEATH (Month) (Day) (Year) July 3, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH July 3 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 4
11. BIRTHPLACE (City and State or Foreign Country) St. Louis		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME William York		13b. MOTHER'S MAIDEN NAME Edith Gibbs	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William York 1016 N. 47th St. East St. Louis	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pre Malaria  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  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) 776X	
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 3, 1953, to July 3, 1953, that I last saw the deceased alive on July 3, 1953, and that death occurred at 11 a. m., from the causes and on the date stated above.			
23a. SIGNATURE H. J. Moore M.D.		23b. ADDRESS 917-5018	
23c. DATE SIGNED 7-4-53		24a. BURIAL, CREMATION REMOVAL (Specify) Removal	
24b. DATE July 6 1953		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
24d. LOCATION (City, town, or county) (State) Watson & McKenzie Road		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G. Hoffmeister Colonial Mortuary 6264 Chippewa St.	
DATE REC'D BY LOCAL REG. III 6 1953		REGISTRAR'S SIGNATURE [Signature]	
(Licensed Embalmer's Statement on Reverse Side)			

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 .....  
Signature of Student Embalmer

*Not Embalmed*  
Signed *Lenius C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.