

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

10426

State File No. _____

Registrar's No. **2649**

BIRTH NO. **94038-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		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 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 3102 School 21	
3. NAME OF DECEASED (Type or Print) a. (First) Gregory b. (Middle) _____ c. (Last) Young		4. DATE OF DEATH (Month) (Day) (Year) 2 11 55	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 12-30-54
9. AGE (In years last birthday) 1 MONTHS 12 DAYS _____ HOURS _____ MIN.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Monroe Young	
13b. MOTHER'S MAIDEN NAME Ruby Williams		14. NAME OF HUSBAND OR WIFE None	
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 Julia E. Mosley, med. Dir. office		ADDRESS _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diarrhea, Dehydration and Acidosis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Undt.	
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		DUE TO (b) _____	
				DUE TO (c) _____	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5710	

22. I hereby certify that I attended the deceased from **2-6**, 19**55**, to **2-11**, 19**55**, that I last saw the deceased alive on **2-11**, 19**55**, and that death occurred at **1:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William N. Sinkler M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 2-24-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 3-31-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howland-Aker Mortuary Service			
DATE REC'D BY LOCAL REG. MAR 24 1955		REGISTRAR'S SIGNATURE J. Carl Smith		26. (Licensed Embalmer's Statement on Reverse Side)	

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

No. 300
10.48

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

Signed.....

Licensed Embalmer No.....

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