

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28606

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2045

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Manchester</u>)		c. LENGTH OF STAY (in this place) <u>5 mo.</u>	c. CITY OR TOWN <u>Hillsdale</u> <u>H16</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Manchester Nursing Home.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS		(If rural, give location) <u>2124 Cherry Ave.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Charles</u>	b. (Middle) <u>C.</u>	c. (Last) <u>Young</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>About 1882</u>	9. AGE (in years last birthday) <u>73?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (unb)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Rolla, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Ellie Young</u>	13b. MOTHER'S MAIDEN NAME <u>Susie Rutherford</u>	14. NAME OF HUSBAND OR WIFE <u>Jane</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>497-03-5225</u>	17. INFORMANT'S SIGNATURE OR NAME <u>James W. Young</u>	ADDRESS <u>6401 Leschen</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CEREBRAL ARTERIOSCLEROSIS</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>CHRONIC MYOCARDITIS</u>			

19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>334X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>—</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>—</u>

22. I hereby certify that I attended the deceased from JULY 5, 1954, to AUG. 28, 1955, that I last saw the deceased alive on AUG. 27, 1955, and that death occurred at 8:45p m., from the causes and on the date stated above.

23a. SIGNATURE <u>B. R. Loving M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>BALLWIN, Mo.</u>	23c. DATE SIGNED <u>9-1-55</u>
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24a. BURIAL CREMATORY (Specify) <u>—</u>	24b. DATE <u>9-2-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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DATE REC'D BY LOCAL REG. <u>9/1/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Dombke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington Blvd.</u>
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. Wm Binkley*

Licensed Embalmer No. *765*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.