FILED SEP 4 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 30212

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7888

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Marys Inf. — Length of stay in 1b: 17 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 4562 Labadie — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: SARA Middle: C. Last: YOUNG
4. DATE OF DEATH: Month 8 Day 22 Year 57
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/23/1887
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months 21 Days 29 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Probation Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): E. St. Louis, Ill.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter A. Young
14. MOTHER'S MAIDEN NAME: Sarah Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Regina Goff, 4562 Labadie (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-5-57, to 8-22-57 and last saw her/him alive on 8-21-57
Death occurred at 8:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: E. Smith, M.D. (Degree or title)
22b. ADDRESS: 1114 Jefferson St. Louis
22c. DATE SIGNED: 8-23-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/24/57
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: Charles J. Gates ADDRESS: 4107 Finney
25. DATE RECD. BY LOCAL REG.: AUG 23 '57
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 18

P. O. Address 4107 Fin

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