

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1957

38393  
STATE FILE NUMBER  
10513

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR Yes <input type="checkbox"/> No <input type="checkbox"/> TOWN St. Louis		c. CITY OR TOWN St. Louis 2069		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips 0		Length of stay in 1b		d. STREET ADDRESS 5518 Labadie (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fred Young			4. DATE OF DEATH Month 11 Day 5 Year 57		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1875	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Lusher Dodge		11. BIRTHPLACE (City and state or country) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wink			
14. MOTHER'S MAIDEN NAME Wink		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.		17. INFORMANT James R. Conway 56 58 <sup>a</sup> Labadie			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Emphysema - Bronchopneumonia					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 10-28-57 to 11-5-57 and last saw him alive on 11-5-57 Death occurred at 1:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Sydney A. Frase M.D. (Degree or title)		22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 11-6-57	
23a. BURIAL, CREMATION, or DISPOSITION		23b. DATE 11-7-57		23c. NAME OF CEMETERY OR CREMATORY Calvary Cem	
23d. LOCATION (City, town, or county) St. Louis Mo		(State)			
24. FUNERAL DIRECTOR Chas. F. Stueck 1225 Union		25. DATE RECD. BY LOCAL REG. NOV 6 '57		26. REGISTRAR'S SIGNATURE Carl Smith MO	

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 *Elton R. Remel*

Licensed Embalmer No. 428

P. O. Address *St. Louis*

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.