

pt. Health,
, & Welfare
S. Public
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ev. 1-57

KC- 1487885
SL- 13994

FILED DEC 13 1957
Registration District No.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
312

1003

42825
STATE FILE NUMBER
Registrar's No. 11804

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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> COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VET. ADM. HOSPITAL</u>		Length of stay in lb <u>8 DAYS</u>	d. STREET ADDRESS <u>2846 Pine St. YMCA</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN H YOUNG</u>			4. DATE OF DEATH Month Day Year <u>12-7-57</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>	11. BIRTHPLACE (City and state or country) <u>JACKSON MISSISSIPPI</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. NAME OF HUSBAND OR WIFE <u>NONE</u>	
13a. FATHER'S NAME <u>CHARLES YOUNG</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE SANDERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, if unknown) (If yes, give war or dates of service) <u>YES WW-1</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>VA HOS P RECORDS</u>		Address <u>915 N GRAND ST. LOUIS MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CARCINOMA OF THE ESOPHAGUS</u> DUE TO (c) <u>150X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 WORK <input type="checkbox"/> 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 <u>VA</u>		COUNTY STATE	
21. I attended the deceased from <u>11-29-57</u> to <u>12-7-57</u> and last saw him alive on <u>12-7-57</u> Death occurred at <u>9:20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John S. Hazelbaker</u> (Type or print name) <u>John S. Hazelbaker</u>		22b. ADDRESS <u>M. D. VAH. ST. LOUIS, MO.</u>	
22c. DATE SIGNED <u>12-8-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/11/57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>	
24. FUNERAL DIRECTOR <u>G. Wade Granberry</u>		ADDRESS <u>4202 Finney Ave.</u>	
25. DATE RECD. BY LOCAL REG. <u>DEC 9 57</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>	

- 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 *Leroy W. Donister*

Licensed Embalmer No. *4523*

Res. Address *4251 Washington*

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.

ev. year in BOSA v. ...