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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031140
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8636

1. PLACE OF DEATH
a. COUNTY City
b. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hosp — Length of stay in 1b 14 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY City
c. CITY OR TOWN St. Louis 12, — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 6182 Washington Ave. — Reside on Farm Yes [ ] No [X]

22 2059

3. NAME OF DECEASED (Type or print) First MR. Middle JOHN WILLIAM Last YOUNG
4. DATE OF DEATH Month Sept. Day 6, Year 1958
5. SEX M. 0
6. COLOR OR RACE W.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH July 27, 1874
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (retired)
10b. KIND OF BUSINESS OR INDUSTRY Gen. Elec. Co.
11. BIRTHPLACE (City and state or country) Pittston, Penn. 1
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William H. Young
13b. MOTHER'S MAIDEN NAME Grace Howarth
14. NAME OF HUSBAND OR WIFE Louise Turner Young
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. 074-01-8014
17. INFORMANT Miss Grace H. Monie Address 6182 Washington

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) UREMIA — INTERVAL BETWEEN ONSET AND DEATH 1 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ARTERIO SCLEROSIS — 6-12 mo
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 450.0

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] 1

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 1947, to 9/6/58 and last saw ~~her~~ him alive on 9-5-58
Death occurred at 6:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE D D Michael MD (Degree or title)
22b. ADDRESS 812 Olive St.
22c. DATE SIGNED 9/6/1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-rail
23b. DATE 9/9/1958
23c. NAME OF CEMETERY OR CREMATORY Vale Cemetery
23d. LOCATION (City, town, or county) Schenectady (State) New York

24. FUNERAL DIRECTOR Alexander & Sons, Inc. ADDRESS 6175 Delmar
25. DATE RECD. BY LOCAL REG. SEP 8 '58
26. REGISTRAR'S SIGNATURE Joel Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6170 Delmar

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.