

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016009

STATE FILE NUMBER

FILED MAY 6 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **3842**

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) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 484 LAKE
3. NAME OF DECEASED (Type or print) First LOUISE Middle TAYLOR Last YOUNG			4. DATE OF DEATH Month APRIL Day 17 , Year 1959
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1873
9. AGE (In years last birthday) 85		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) SUPT. MAINE SCHOOL DEAF TEACHING		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) JACKSONVILLE ILL
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME JOHN WILSON Young	
13b. MOTHER'S MAIDEN NAME REBECCA TAYLOR		14. NAME OF HUSBAND OR WIFE NONE	
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. NONE	17. INFORMANT Address Dr. Wm. H. Ohlsted 484 LAKE ST.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO (b) Atherosclerosis general DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <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 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 FEB. 12, 1953 to APRIL 17, 1959 and last saw her alive on APRIL 17, 1959 Death occurred at 2:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W H Ohlsted (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 4/18/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-18-59	23c. NAME OF CEMETERY OR CREMATORY LOCAL	23d. LOCATION (City, town, or county) (State) JACKSONVILLE ILL;
24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons 7233 DELMAR		25. DATE RECD. BY LOCAL REG. APR 18 '59	26. REGISTRAR'S SIGNATURE Earl Smith. M.D. m d b.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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1-57
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291
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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 .. *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.