

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019803  
STATE FILE NUMBER

2-4622  
Registration No.

FILED MAY 26 1959

Registration District No.

Primary Registration District No.

Registration No.

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL diseases in Part I must be causally related.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>3033a N. Sarah</b>  |                                  | Length of stay in lb  | d. STREET ADDRESS (If outside, give location)<br><b>3033a N. Sarah</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>MARIE</b> Last <b>YOUNG</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>9</b> Year <b>1959</b>  |
| 5. SEX<br><b>Female</b> <sub>3</sub>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 29, 1873</b>  |
| 9. AGE (In years by birthday)<br><b>85</b>  |                                  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  | 11. BIRTHPLACE (City and state or country) /<br><b>Summerfield, Illinois</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                  | 13a. FATHER'S NAME<br><b>Frank Hart</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Dora ?</b>  |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>John H. Young</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>349-32-6948</b>   |   |
| 17. INFORMANT<br><b>Clarice Saunders</b>  |                                  | Address<br><b>3033a N. Sarah</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO (c) <b>Unknown</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>443x</b>  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour Month, Day, Year<br>a.m.<br>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 <b>18 Feb 1959</b> to <b>8 May 1959</b> and last saw her alive on <b>8 May 1959</b><br>Death occurred at <b>2:30 a.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |
| 22a. SIGNATURE<br><b>Mason D. Clay</b> (Degree or title)  |                                  | 22b. ADDRESS<br><b>914 N. Taylor</b>  | 22c. DATE SIGNED<br><b>11 May 59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>5/12/59</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>College Hill Cemetery</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Lebanon, Illinois</b>   |
| 24. FUNERAL DIRECTOR<br><b>Charles J. Gates</b>   |                                  | ADDRESS<br><b>4107 Finney</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 12 '59</b>   |
|   |                                  |   | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b><br><i>m.d.c.</i>   |

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 ..... *Guylton Swann*

Licensed Embalmer No. *4580* or *90*

P. O. Address *4107 Finney Ave*

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.