

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019948

STATE FILE NUMBER

FILED JUN 9 1959

Registration District No. **817**

Primary Registration District No. **590**

Registrar's No. **151**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Hillsdale</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hillsdale 4161.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2146 Overlea Ave</b>		Length of stay in lb <b>6 years</b>	d. STREET ADDRESS (If outside, give location) <b>2146 Overlea Avenue</b>
			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>YATES</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1874</b>	9. AGE (In years birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>N.Y.C. Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Fort Wayne Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Yates</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Chenevare</b>	14. NAME OF HUSBAND OR WIFE <b>Ella Yates</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>714-03-5177</b>	17. INFORMANT Address <b>Mrs. Cora Kuse, 2146 Overlea Avenue.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Coronary thrombosis</b>		<b>4201</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchopneumonia, Chronic Emphysema</b>		19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour <b>12:15 P.M.</b> Month, Day, Year	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 <b>Hammond, Indiana</b>	COUNTY <b>Hammond, Indiana</b>	STATE
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21. I attended the deceased from <b>5/13/59</b> to <b>6/1/59</b> and last saw <sup>her</sup> him alive on <b>6/1/59</b> Death occurred at <b>12:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Murray Chinsky, M.D.</b>	22b. ADDRESS <b>6223 Natural Bridge</b>	22c. DATE SIGNED <b>6/2/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 3, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Hammond, Indiana</b>
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24. FUNERAL DIRECTOR <b>Shepard Funeral Home, 1167 Hamilton Ave</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	REGISTRAR'S SIGNATURE <b>John C. Murphy M.D. Jr.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service  
300  
-57  
All diseases in Part I must be causally related.

Dr. Ross and  
Co Health Dept  
Vice Train

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 *Robert M. Murray*

Licensed Embalmer No. *3749*  
P. O. Address *St. Louis, Mo*

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.