

FILED VS AUG 5 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027383  
STATE FILE NUMBER  
26928  
Registration No. 6928

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

S. 300

v. 1-57

28  
69/101

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.

m Bell goes out 101

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>6183 Bertha</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha M Young</b>			4. DATE OF DEATH Month Day Year <b>7 19 59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>3 Negro</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>2-10-1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>NEWPORT ARK</b>
13a. FATHER'S NAME <b>DAVID ROBINSON</b>		13b. MOTHER'S MAIDEN NAME <b>GRACIE ROBINSON</b>	14. NAME OF HUSBAND OR WIFE <b>? YOUNG</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MRS WILLIAMS. 4603. NEWBERRY JR</b>
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>UREMIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIO-SCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <b>442X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>HYPERTENSIVE HEART DISEASE, CARDIOVASCULAR DISEASE,</b>			
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 o.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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>6-26-59</b> , to <b>7-19-59</b> and last saw him alive on <b>7-19-59</b> Death occurred at <b>6:50 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul H. Larson, M.D.</i> (Degree or title)		22b. ADDRESS <b>2601 N. Whittier St.</b>	22c. DATE SIGNED <b>7-22-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>7-27-59.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FATHERDICKSON. COUN</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS-COUNTY. MO</b>
24. FUNERAL DIRECTOR <b>PEASTON FUNERAL 3615 EASTON</b>		25. DATE RECD. BY LOCAL REG. <b>7 JUL 27 1959</b>	26. REGISTRAR'S SIGNATURE <i>Loart Smith, M.D.</i>

M. J. B.

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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

*Walter R. Williams*

5135 Lotus

Licensed Embalmer No. 4926

P. O. Address .....

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.