

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959

59-030920

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7880** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>MORGAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		Length of stay in 1b <b>79 DAYS</b>	c. CITY OR TOWN <b>JACKSONVILLE</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>VETS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>437 S. CLAY</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>R.</b> Last <b>YOUNG</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>23</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>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>9/13/90</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City or state or country) <b>JACKSONVILLE, ILL.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>GEORGE YOUNG</b>		13b. MOTHER'S MAIDEN NAME <b>GRACE REED</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>331-14-5031</b>	17. INFORMANT Address <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO</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>VASCULAR SHOCK</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>DISSEMINATED CARCINOMA METASTASES</b>	
		DUE TO (c) <b>CARCINOMA OF LUNG</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>-</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m. Month, Day, Year _____	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 **6/5/59** to **8/23/59** and last saw him alive on **8/23/59**  
Death occurred at **4:55 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>MARTIN F. STEIN</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>VAH, ST LOUIS, MISSOURI</b>		22c. DATE SIGNED <b>8/25/59</b> (Star)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-27-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Diamond Grove Cemetery</b>	23d. LOCATION (City, town, or county) <b>Jacksonville, Illinois.</b>	

24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 24 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

