

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034525**

**FILED OCT 13 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **8 8999**

RECEIVED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D. O. A. CITY HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2217 MC NAIR</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR YORK</b>			4. DATE OF DEATH Month Day Year <b>SEPT 29 1959</b>			
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 16 1886</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MAINTENANCE MAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HEIL PACKING</b>	11. BIRTHPLACE (City and state or country) <b>ENGLAND U-S-A</b>	12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>
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13a. FATHER'S NAME <b>THOMAS YORK</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>STELLA A YORK</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</b>	16. SOCIAL SECURITY NO. <b>488-03-5968</b>	17. INFORMANT Address <b>STELLA A YORK 2217 MC NAIR</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>coronary embolism,</b>		<b>1 day</b>
DUE TO (b) <b>coronary thrombosis</b>		<b>5 mo.</b>
DUE TO (c) <b>widespread myocarditis</b>		<b>14 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
<b>Hypertension Chronic</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension Chronic</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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>None</b>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <b>None</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from <b>Nov. 10 1955</b> to <b>Sept 29 1959</b> and last saw <sup>her</sup> him alive on <b>September 27 1959</b> Death occurred at <b>7:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Jno C. Doubek</b> (Print name or title) <i>Jno C. Doubek M.D.</i>	22b. ADDRESS <b>2767 Gravois</b> <i>2767 Gravois St. St. Louis 18 Mo</i>	22c. DATE SIGNED <b>9-30-59</b>
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23a. BURIAL, CREMATION, REMOVAL (specify) <b>REMOVAL</b>	23b. DATE <b>OCT 2 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKEWOOD PARK CEM</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Thomas Kutis 2906 Gravois</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 3 0'59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>msb</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Eleana Province*

Licensed Embalmer No. 3403

P. O. Address 2906 Pra

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.