

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

**59-034526**

**FILED VS SEP 29 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8530**

WENDED

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (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>	Length of stay in 1b <b>Life.</b>	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>Chronic Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>4726a Olive St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ida</b> Middle <b>Mary</b> Last <b>Young</b>	<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>13</b> Year <b>59</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Col.</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/14/25</b>	<b>9. AGE (last birthday)</b> <b>34</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bar-Maid</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Moulin Rouge Tavern</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Mo. (St. Louis)</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>
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<b>13a. FATHER'S NAME</b> <b>John Watkins</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Estelle Merceries</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>-- Robert Young</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>498-26-8378</b>	<b>17. INFORMANT</b> <b>Estelle Jeffries</b>	<b>Address</b> <b>4726a Olive</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <b>acute Pyelonephritis - bilat.</b>		<b>3 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <b>6 wks.</b>	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a) <b>Hemorrhagic Cystitis - 3 wks.</b>	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	<b>Month, Day, Year</b>
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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<b>21. I attended the deceased from</b> <b>6-8-59</b> , to <b>9-13-59</b> and last saw her/him alive on <b>9-13-59</b> Death occurred at <b>5:55 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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<b>22a. SIGNATURE</b> (Degree or title) <b>John W. Beckham, M.D.</b>	<b>22b. ADDRESS</b> <b>5800 Arsenal</b>	<b>22c. DATE SIGNED</b> <b>9/13/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>9/19/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenwood Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Charles J. Gates</b>	<b>ADDRESS</b> <b>4107 Finney</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 16 59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

*Gupton Swan*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Av

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.