

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAINT LOUIS		Length of stay in lb 32 DAYS	c. CITY OR TOWN GRANITE CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LITTLE FLOWER CONVALESCENT HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2315 E. 19TH ST.

3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last YOUNG			4. DATE OF DEATH Month 8 - Day 12 - Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1873	9. AGE (last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) HOUSTON Co., TENN.	12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME WILLIAM YOUNG	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
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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) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Paul Knight	Address BERGLER STREET GLEN CARBON, ILL.
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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) Arteriosclerotic Heart Disease		
DUE TO (b) Generalized Arteriosclerosis		
DUE TO (c) +20.0		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <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 a.m. _____ p.m. _____	Month, Day, Year
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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 _____
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21. I attended the deceased from **June 24 thru July August 12, 1960**, and last saw her alive on **July 8, 1960**
 Death occurred at **3:45 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Alma L. Thibe MD	22b. ADDRESS 4520 Olive St	22c. DATE SIGNED 8/12/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-12-1960	23c. NAME OF CEMETERY OR CREMATORY BLOOMING GROVE	23d. LOCATION (City, town, or county) (State) CUMBERLAND CITY, TENN.
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24. FUNERAL DIRECTOR W. W. Wallace	ADDRESS GRANITE CITY, TENNESSEE	25. DATE RECD. BY LOCAL REG. AUG 12 1960	26. REGISTRAR'S SIGNATURE Paul Knight M.D.
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DOCUMENT
MEDICAL CERTIFICATION
Funeral Director
BY AFFIDAVIT OF

*Paul Knight
Sept 15/60*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Wilcox

Licensed Embalmer No. 3951

P. O. Address St. Louis

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.