

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1960 318 1003 10774 -60-044427
 Registration District No. Primary Registration District No. Registrar's No. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 55 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5937 Hamilton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Young Last Young				4. DATE OF DEATH Month Nov. Day 7 Year 1960				
5. SEX male	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 ab. 1870	9. AGE (last birthday) ab 90	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during life working life, even if retired) scribe		10b. KIND OF BUSINESS OR INDUSTRY Religious Goods		11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Leib Young			13b. MOTHER'S MAIDEN NAME (unknown)			14. NAME OF HUSBAND OR WIFE Sarah		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give no or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Louis Young		Address 1320 Grant		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia from Food Aspiration						INTERVAL BETWEEN ONSET AND DEATH 1 minute		
DUE TO (b) Malnutrition, severe						1 year		
DUE TO (c) Renal dysfunction unknown origin						? mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hyponatremia of Renal origin						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 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.) 603x				
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 1956 to 11/7/60 and last saw him live on 11/7/60 Death occurred at 11:40 AM m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Clifford R. Yalbert, M.D.				22b. ADDRESS 2165 Kings Highway		22c. DATE SIGNED 11/7/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 11-8-60	23c. NAME OF CEMETERY OR CREMATORY Chese d Shel Emeth Cem.		23d. LOCATION (City, town, & county) (State) Univ. City, Mo.			
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson				25. DATE RECD. BY LOCAL REG. NOV 8 1960		26. REGISTRAR'S SIGNATURE Clifford R. Yalbert, M.D.		

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Samuel J. Davis*

Licensed Embalmer No. 398

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.