

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2215 STATE FILE NUMBER 61-011818

AMENDED FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2/mo.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Henry Chronic Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>710a Mari on St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Young</u> Last	4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>61</u>
--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Indian</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/03</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	-----------------------------------	---	------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Never Worked</u>	11. BIRTHPLACE (City and state or country) <u>Seattle, Wash.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>Esaw Young</u>	13b. MOTHER'S MAIDEN NAME <u>Lokaine Harrison</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Rabby Young, 917 1/2 Park, St. Louis, Mo.</u>
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary artery sclerosis</u> DUE TO (c) <u>420.1</u>	INTERVAL BETWEEN ONSET AND DEATH
--	----------------------------------

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 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.)
---	---	--

20c. TIME OF INJURY Hour <u>2:50</u> 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 <u>St. Louis</u>	COUNTY <u>St. Louis Co.,</u>	STATE
--	--	--	---------------------------------	-------

21. I attended the deceased from 1-3-61 to 3-4-61 and last saw her him alive on 3-4-61
Death occurred at 2:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank B. Crust M.D.</u> (Degree or title)	22b. ADDRESS <u>500 Arsenal St</u>	22c. DATE SIGNED <u>3-6-61</u>
--	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u> (State)
---	----------------------------	---	--

24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette (4)</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR 6 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
---	---	--

DATE PRINTED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 *James R. Chapman*
Licensed Embalmer No. 4550
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.