

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047046

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11789**

AMENDED

**FILED JAN 5 1962**

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>ST. LOUIS CITY HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3117 S. JEFFERSON AVE</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>YOUNG</b> Last			4. DATE OF DEATH Month <b>DEC</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 15 1889</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FOREMAN WARNER HUDNUT CO</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MASSACHUSETTS U-5-A</b>		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>UNKNOWN</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MARTHA WREN 3117 S. JEFFERSON</b>	Address
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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>Arterio Sclerotic Heart Disease;</b>			
DUE TO (b) <b>Arterio Sclerosis</b>			
DUE TO (c) <b>4200</b>			

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	
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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.)	
20c. TIME OF INJURY Hour <b>5:00</b> 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	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ **5:00 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Heleen L Taylor, Coroner</b>	(Degree or title)	22b. ADDRESS <b>1300 Clark Ave.</b>	22c. DATE SIGNED <b>12-18-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-19-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MATTHEWS</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>
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24. FUNERAL DIRECTOR <b>Thomas Nutis 2906 Gravois</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>DEC 18 1961</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

**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 *Carol J. Hayes*  
Licensed Embalmer No. *9486*  
P. O. Address *Clayton 5 Mo*

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.