BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 007122-65

STH NO.
I.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RALPH STUART YOUNG
2. DATE AND HOUR OF DEATH: 1-24-65 | 3:45 P.M.
PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LANKENAU Hospital, LOWER MERION Twp. MONTG. Co. PA
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PA
B. COUNTY: MONTG.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WYNNEWOOD
D. STREET ADDRESS (If rural, give location): 32B - WYNNEWOOD PK APTS.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 9-19-1888
9. AGE (In years last birthday): 76
If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET BALL PLAYER
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): PHILA. PA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: CHAS. YOUNG
14. MOTHER'S MAIDEN NAME: LILLIE JONES
Was Deceased ever in U. S. Armed Forces? (Yes or No or unknown) (If yes, give war or dates of service)
15. SOCIAL SECURITY NO.: 177-14-9998
17. INFORMANT: ETHEL YOUNG
ADDRESS: WYNNEWOOD, PA
18. SPOUSE ETHEL K. YOUNG

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	CEREBRAL HEMORRHAGE	3 DAYS
(B) DUE TO	HYPERTENSIVE CARDIO-VASCULAR DISEASE	10 YRS.
(C)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): no.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-24-65
23C. PHYSICIAN'S NAME (Type): DR. WELTY / H. THOMAS DODDS M.D.
23D. ADDRESS: LAUKENAU Hosp. PHILA. PA.

24A. BURIAL CREMATION REMOVAL (Specify): BURIAL
24B. DATE: 1-28-65
24C. NAME of CEMETERY or CREMATORY: WESTMINISTER
24D. LOCATION (City, town, or county) (State): CYNWYD. MONTG. Co. PA.

25A. DATE REC'D BY HEALTH DEPT.: 1-25-65
25B. NAME OF REGISTRAR: JOSEPH A. FARRELL
25C. FUNERAL DIRECTOR: ANDREW J. BAIR & SON, 8925 CHESTNUT ST. PHILA. PA.
ADDRESS

50-REV. 1/1/65