

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3575
Registrar's No. 00212

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6576

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		d. STREET ADDRESS (If rural, give location) 1422 Singleton	
3. NAME OF DECEASED a. (First) Richard b. (Middle) Davis c. (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) 1 23 49
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower	8. DATE OF BIRTH 8-13-14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) porter		10b. KIND OF BUSINESS OR INDUSTRY unknown	9. AGE (In years last birthday) 34
11. BIRTHPLACE (State or foreign country) Holland Knoll, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William Johnson		13b. MOTHER'S MAIDEN NAME Ollie last name unknown	14. NAME OF HUSBAND OR WIFE Olivia Whitehead
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Koch Hospital records Koch, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 13 hr DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. D.D.J.	
19a. DATE OF OPERATION 4-14-48 8-4-48		19b. MAJOR FINDINGS OF OPERATION Thoracoplasty	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 1-16-48, 19__, to 1-23-49, 19__, that I last saw the deceased alive on 1-23-49, 19__, and that death occurred at 5:50 p.m., from the causes and on the date stated above.			
23a. SIGNATURE John R. Beem, M.D.		23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 1-24-49
24a. BURIAL, CREMATION/REMOVAL (Specify) Shipped		24b. DATE Jan 28/49	24c. NAME OF CEMETERY OR CREMATORY Clarkdale Miss
24d. LOCATION (City, town, or county) Miss		24e. (State)	
DATE REC'D BY LOCAL REG. 1-27-49		REGISTRAR'S SIGNATURE Thurel V. Lunn	
25. FUNERAL DIRECTOR'S SIGNATURE F.C. Keen		ADDRESS 4214 Delmar	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed J. C. Green.....

Signed.....
Student Embalmer

Licensed Embalmer No. 2963.....

P. O. Address 4214 Delmar.....

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 this body is not embalmed, fact should be so stated above.