

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35271

State File No. ....

318

1003

9204

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hazel</u>		b. (Middle) _____		c. (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 25 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>4-22-1912</u>	
9. AGE (In years last birthday) <u>37</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>CHARLESTON MISS</u>	
11. BIRTHPLACE (State or foreign country) <u>CHARLESTON MISS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>TOM POWELL</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISE UNKNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>LOUISE UNKNOWN</u>		14. NAME OF HUSBAND/OR WIFE <u>JOE JOHNSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joe Johnson 2928 DELMAR</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the Cervix with extensive Metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
		ANTECEDENT CAUSES DUE TO (b) <u>Undetermined</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Abdominal Fecal Fistula</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>ST LOUIS MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>171X</u>			
22. I hereby certify that I attended the deceased from <u>10-7</u> , 19 <u>49</u> , to <u>10-25</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-25</u> <u>10-49</u> and that death occurred at <u>12:55a m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Montague Lawrence M.D.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>10-25-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>10-28-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>OCT 26 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alleen DeLuca 3506 Paulina</u>			

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

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4441

P. O. Address 3506 Frankla

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.