

FILED MAY 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18317

State File No.

30773-50

318

1433

BIRTH NO. 12190 REG. DIST. NO. PRIMARY REG. DIST. 1002 Registrar's No. 1433

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, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> (2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1602 McMillan McMillan</u>		d. STREET ADDRESS (If rural, give location) <u>4602 McMillan</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Infant Baby</u> b. (Middle) c. (Last) <u>Johnson #3</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-11-50</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cel</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>5-11-50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 14 YEAR MONTHS DAYS HOURS MIN. <u>50</u>
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Willie Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Curtis</u>	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)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Willie Johnson - 4602 McMillan</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>7</u> DUE TO (c) <u>1 lb. 13 oz.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
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) <u>Prematurity</u>	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</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?

22. I hereby certify that I attended the deceased from 5-11, 1950, to 5-11, 1950, that I last saw the deceased alive on 5-11, 1950, and that death occurred at 10 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Carl Woolley, M.D.</u>	(Degree or title)	23b. ADDRESS <u>630 So. Kingshighway Blvd.</u>	23c. DATE SIGNED <u>5-17-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>10</u>	24b. DATE <u>MAY 18 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL <u>MAY 18 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Foster</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ronald W. ... 45104 ...</u>
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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. _____

P. O. Address _____

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.