S. No. 300
v. 10-48

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28333

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7373

0

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

1. PLACE OF DEATH
a. COUNTY: St. Louis-Missouri
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2109
d. STREET ADDRESS (If rural, give location): 3007 Vine Grove 0

3. NAME OF DECEASED (Type or Print)
a. (First): Laverne
b. (Middle):
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): August 26 1950

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Nill 0
8. DATE OF BIRTH: July 8 1950
9. AGE (In years last birthday): If under 1 year: Months 1 Days 20; If under 1 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Nill
11. BIRTHPLACE (State or foreign country): St. Louis 0
12. CITIZEN OF WHAT COUNTRY?: Yes

13a. FATHER'S NAME: levert Johnson
13b. MOTHER'S MAIDEN NAME: Ada Bell Davis
14. NAME OF HUSBAND OR WIFE: Ada Bell Johnson

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: Levert Johnson
ADDRESS: 3007 Vine Grove

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): Hydro-Pneumothorax
INTERVAL BETWEEN ONSET AND DEATH: Undetermin

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cause Undetermined
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 579.2

22. *I hereby certify that I attended the deceased from* 8-17, 19 50, *to* 8-26, 19 50, *that I last saw the deceased alive on* 8-26, 19 50 *and that death occurred at* 9:57p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. S. Lawrence M. D.
23b. ADDRESS: 2601 N Whittier St.
23c. DATE SIGNED: 8-29-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 8/29/50
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): 9500 Natural Bridge Mo

DATE REC'D BY LOCAL REG.: AUG 29 1950
REGISTRAR'S SIGNATURE: J. B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Herman J. SMITH
ADDRESS: 4247/w Labadie Ave

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.