

FILED SEP 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31738**
Registrar's No. **7820**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2247	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) W 1326a Arsenal	
3. NAME OF DECEASED (Type or Print) a. (First) WADE b. (Middle) H. c. (Last) JOHNSTONE		4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 19, 1900
9. AGE (In years last birthday) 50		10. KIND OF BUSINESS OR INDUSTRY Salesman	11. BIRTHPLACE (State or foreign country) Hoboken, New Jersey
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Gabriel Johnstone		13b. MOTHER'S MAIDEN NAME Katherine Kennally	
14. NAME OF HUSBAND OR WIFE Marie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. #1	
16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Marie Johnstone ADDRESS I326a Arsenal, St. Louis, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound of skull and brain self inflicted on porch of house Arsenal Arsenal 820 am ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sept. 15, 1950 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Suicide	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) suicide	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 15 50 8:20 A.M.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? E976X		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:29A.M. , from the causes and on the date stated above.	
23a. SIGNATURE Catrick E. Taylor (Degree or title) Council		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 9.15.50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Sept. 18, 1950		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister ADDRESS 7814 So. Broadway, St. Louis,	
DATE REC'D BY LOCAL REG. SEP 15 1950		REGISTRAR'S SIGNATURE [Signature]	

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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.

Student
Student Embalmer

Signed Linus C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.