

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6264**
Registrar's No. **1946**

BIRTH NO. 10344-51 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 township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2119	
c. LENGTH OF STAY (In this place) 5 hrs.		d. STREET ADDRESS (If rural, give location) 4118 St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Infant Johnson		2 16 51	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ()	8. DATE OF BIRTH 2-16-51
9. AGE (In years last birthday) 2		10. UNDER 1 YEAR Months 0 Days 0	11. UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
		Walter Johnson	
13b. MOTHER'S MAIDEN NAME		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	
Father M. Sherrill		2601 N. Whittier	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
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	
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)			
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?		776X	
22. I hereby certify that I attended the deceased from 2-16-51 , to 2-16-51 , that I last saw the deceased alive on 2-16-51 , and that death occurred at 6:00a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title)		23b. ADDRESS	
M. D.		2601 N. Whittier	
23c. DATE SIGNED			
2-21-51			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
		FEB 28 1951	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Anatomical Bours			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
FEB 28 1951		J. B. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Rowland Mortuary Service Inc.			

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.