

FILED MAR 2 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6266

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1005		Registrar's No. 1614	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (where deceased lived. If institution: residence before admission).			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO				c. LENGTH OF STAY (In this place) 2 PR TOWN			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillip Hospital				e. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO			
f. STREET ADDRESS 620 N Beaumont				g. DATE OF DEATH (Month) (Day) (Year) 2-13-51			
3. NAME OF DECEASED (Type or Print)		a. (First) Aline		b. (Middle) Johnson		c. (Last)	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Not known abt 39		9. AGE (In years last birth day)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nashville Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Not known		13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Edward			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Tommie Doss 620 N Beaumont			
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) 1. Gas Ether Anesthesia ANTECEDENT CAUSES 2 - Pulmonary Edema Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 3 - Thy stercotomy while undergoing DUE TO (c) An operation at Homer Phillip Hospital on Feb-13-1951				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 620 N Beaumont		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 622X					
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 12:00 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Joseph M. Zumbach Deputy (Degree or title)				23b. ADDRESS 1300 Edward		23c. DATE SIGNED 2/17/51	
24a. BURIAL - CREMATION, REMOVAL (Specify)		24b. DATE 2-28-51		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis MO	
DATE REC'D BY LOCAL FEB 17 1951		REGISTRAR'S SIGNATURE J. B. Lusater		25. FUNERAL DIRECTOR'S SIGNATURE A. H. Beal		ADDRESS und 64303 Edward	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Arthur L. Heilbard

Signed.....

Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4740th Coupler*

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.