

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. 7-16-51 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2427

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> <u>4000</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>JEFFERSON BARRACKS, MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u> <u>2239</u>	
c. LENGTH OF STAY (In this place) <u>3 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>23 1618 A S. BROADWAY</u> <u>1</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>VETERANS ADM. HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>GEORGE</u> b. (Middle) <u>EDWARD</u> c. (Last) <u>JOHNSON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-12-51</u>		
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5. SEX <u>MALE</u> <u>0</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10-17-1883</u>	9. AGE (In years last b'orn) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>CROCKER, MISSOURI</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>JOHN A. JOHNSON</u>	13b. MOTHER'S MAIDEN NAME <u>ISABELLE HENSON</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of date of service) <u>YES</u> <u>SPAW</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>VA HOSPITAL RECORDS</u>	ADDRESS _____
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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) <u>PNEUMONIA, BRONCHIAL</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</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>491X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>VA</u>	21e. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 6-10-51, 1951, to 6-12-51, 1951, that I last saw the deceased at home, and that death occurred at 7:10 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Stanley M. Ward</u> M.D.	23b. ADDRESS <u>VET ADM HOSP, JEFF BRKS MO</u>	23c. DATE SIGNED <u>6-12-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-15-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>
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DATE REC'D BY LOCAL REG. <u>6-14-51</u>	REGISTRAR'S SIGNATURE <u>Richard A. Lomax MD</u>	FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin</u>	ADDRESS <u>2301 Poppyette</u>
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WRITE PLAINLY - USING UNFAADING BLACK INK - MAKE 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
Student Embalmer

Student Embalmer No. _____

Signed _____

L. B. Cooper

Licensed Embalmer No. *5633*

P. O. Address *2317 Lafayette*

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.