

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28387

State File No.

7509

FILED SEP 1 1951

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

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Sparta	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 304 W. Jackson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Grath	b. (Middle) Boone	c. (Last) Johnson	4. DATE OF DEATH (Month) (Day) (Year) Aug. 23, 1951
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 16, 1888	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR: MONTHS _____ DAYS _____	IF UNDER 10 HRS. _____ MIN. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Cayce, Ky.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Hershel Johnson	13b. MOTHER'S MAIDEN NAME Mary Miller	14. NAME OF HUSBAND OR WIFE Mona
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mona R. Johnson, Sparta, Ill.	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor ANTECEDENT CAUSES Malignant 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 8-21-51	19b. MAJOR FINDINGS OF OPERATION Brain tumor	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 193X
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22. I hereby certify that I attended the deceased from **8-15, 1951**, to **8-23, 1951**, that I last saw the deceased alive on **8-22, 1951**, and that death occurred at **12:55** m., from the causes and on the date stated above.

23a. SIGNATURE Robert D. Woolsey (Degree or title)	23b. ADDRESS 16 Hamptonville	23c. DATE SIGNED 23 Aug
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-23-51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Sparta, Ill.
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DATE REC'D BY LOCAL REGISTRY AUG 23 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Robert Rennie

Licensed Embalmer No.

4199

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.