

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35217

State File No. \_\_\_\_\_

FILED OCT 23 1951

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8992

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ST. LOUIS, MO.</u> )		c. CITY (If outside corporate limits, write RURAL and give township) <u>1 MONTH</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mt. Vernon</u> <u>8120</u>	
d. STREET ADDRESS <u>700 So. Eighteenth</u>		d. STREET ADDRESS (If rural, give location) <u>8</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>A.</u> c. (Last) <u>JOHNSON, M.D.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 10 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 20-1882</u>
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>	
11. BIRTHPLACE (State or foreign country) <u>Dale, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>John Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Louisa Harrelson</u>	
14. NAME OF HUSBAND OR WIFE <u>Louise Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Louise Johnson</u>		ADDRESS <u>Mt. Vernon Ill</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of the Liver</u>  INTERVAL BETWEEN ONSET AND DEATH <u>3 years</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) _____  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? <u>3810</u>			
22. I hereby certify that I attended the deceased from <u>9-11</u> , 19 <u>51</u> , to <u>10-10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>10-10</u> , 19 <u>51</u> , and that death occurred at <u>10:25 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Sidney Goldberg M.D.</u>		23b. ADDRESS <u>BARNES HOSPITAL</u>	
23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-11-51</u>	
24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>McCleansboro, Ill</u>	
DATE REC'D BY LOCAL REG. <u>Oct 11 1951</u>		REGISTRAR'S SIGNATURE <u>Albert H. Hoppe</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington</u>	

WRITE PLAINLY—USING UNFADEING 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. ....

Student .....  
Student Embalmer

Signed *John S. Penner*

Licensed Embalmer No. *4194*

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.