

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10165**
Registrar's No. **2840**

FILED APR 12 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: JEWISH HOSPITAL		d. STREET ADDRESS (If rural, give location) 5879 Etzel Avenue.	

3. NAME OF DECEASED (Type or Print)	a. (First) VIRGINIA	b. (Middle) W.	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) March 25, 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Ost 24, 1897	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 2 WKS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Clerk	10b. KIND OF BUSINESS OR INDUSTRY Statler Hotel	11. BIRTHPLACE (State or foreign country) Framingham, Mass.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Oliver Root	13b. MOTHER'S MAIDEN NAME Clara Marshall	14. NAME OF HUSBAND OR WIFE Freeman Johnson.
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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. 490-12-3240	17. INFORMANT'S SIGNATURE OR NAME Freeman Johnson, 5879 Etzel Avenue.	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Duodenum with metastases.		
	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 checked="" type="checkbox"/> NO <input 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? 175X
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22. I hereby certify that I attended the deceased from **October, 1946**, to **3/25, 1952**, that I last saw the deceased alive on **3/25, 1952**, and that death occurred at **5 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Leah Foster M.D.	(Degree or title)	23b. ADDRESS 727 Mo. Theatre Bldg	23c. DATE SIGNED 3/24/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) IL	24b. DATE March 27, 1952	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 26 1952	REGISTRAR'S SIGNATURE Paul Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Shepard Funeral Home, 1167 Hamilton Avenue	ADDRESS
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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

J. Wm. Binkley

Licensed Embalmer No. _____

3653

P. O. Address _____

St. Louis, Mo.

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.