

XC-4637144

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18927

REG. #98832

State File No.

FILED MAY 17 1952

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1266

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| 1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN <u>JEFFERSON BRKS., MO.</u> | | c. CITY OR TOWN <u>NEW FLORENCE</u> | |
| c. LENGTH OF STAY (in this place) <u>147 DAYS</u> | | d. STREET ADDRESS (If rural, give location) <u>NONE</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADM. HOSPITAL</u> | | | |

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|-------------------------------------|-----------------------|--------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>LEO</u> | b. (Middle) <u>(NMI)</u> | c. (Last) <u>JOHNSON</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>5-12-52</u> |
|-------------------------------------|-----------------------|--------------------------|--------------------------|--|

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|--------------------|-------------------------------|--|---------------------------------|--|------------------------|-----------------------|-----------------------|----------------------|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>8-19-17</u> | 9. AGE (In years last birthday) <u>34 YRS.</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. 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 <u>UNKNOWN</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>BELL FLOWER, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>ROY JOHNSON</u> | 13b. MOTHER'S MAIDEN NAME <u>CORDIE CLARK</u> | 14. NAME OF HUSBAND OR WIFE <u>NONE</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify unknown) (If yes, give year or dates of service) <u>YES WW-II</u> | 16. SOCIAL SECURITY NO. <u>UNKNOWN</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) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>SARCOMA HYPOPHARYNX</u> | | DUPLICATE | | <u>UNKNOWN</u> |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 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. | | |

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| 19a. DATE OF OPERATION <u>2-18-52</u> | 19b. MAJOR FINDINGS OF OPERATION <u>SARCOMA HYPOPHARYNX</u> | 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) (Minute) <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 12-17-51 to 5-12-52, 1952, and that death occurred at 2:10 AM, from the causes and on the date stated above.

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| 23a. SIGNATURE <u>R.A. ALLEN</u> (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>VET ADM HOSP, JEFF BRKS, MO.</u> | 23c. DATE SIGNED <u>5-12-52</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>5-12-52</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Montgomery City, Mo.</u> | 24d. LOCATION (City, town, or county) (State) <u>Montgomery City, Mo.</u> |
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| DATE REC'D BY LOCAL REG. <u>5-12-52</u> | REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>SCHLANKER FUNERAL HOME, NEW FLORENCE, MO.</u> | ADDRESS |
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

OCT 15 1952

MAY 17 1952

DEC 11 1958

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Etienne M. Remeluis

Licensed Embalmer No. 4283

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.