V.S. No. 300
Rev. 10.48

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

FILED SEP 8 1952

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 29639

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8097

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo
b. COUNTY: 2214
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 2914 N-19 St

3. NAME OF DECEASED (Type or Print): a. (First) O. b. (Middle) D. c. (Last) Johnson
4. DATE OF DEATH (Month) (Day) (Year): 8-25-52
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8-2-1901
9. AGE (In years last birthday): 51 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): Clarksville Miss
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME: O. D. Johnson
13b. MOTHER'S MAIDEN NAME: Cora Vaughns
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Ivory Jones — ADDRESS: 914 N 18 St

**MEDICAL CERTIFICATION**

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 wks.

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive Cardiovascular Disease — Many yrs.
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 [XX] NO [ ]

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) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 443 X

22. *I hereby certify that I attended the deceased from* Aug. 24, 1952, *to* Aug 25, 1952 *that I last saw the deceased alive on* Aug 25, 1952 *and that death occurred at* 12 00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: F. R. Bradley (Degree or title) M.D.
23b. ADDRESS: BARNES HOSPITAL
23c. DATE SIGNED: 8/25/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-1-52
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St Louis County Mo

DATE REC'D BY LOCAL REG.: AUG 26 1952
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: C. P. Richardson — ADDRESS: 2625 Gravois
(Licensed Embalmer's Statement on Reverse Side)

## 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 D E Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.