

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36529**
Registrar's No. **9666**

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

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 4001 Enright Ave	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) _____ c. (Last) Johnson		4. DATE OF DEATH (Month) (Day) (Year) Oct. 17 1952	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 3, 1897
9. AGE (In years last birthday) 55	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State, or Foreign Country) Washington Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Andrews Johnson	
13b. MOTHER'S MAIDEN NAME Ellen Cruise		14. NAME OF HUSBAND OR WIFE Never Married	
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. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Marjorie Jones	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate with Metastasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
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? 177X		22. I hereby certify that I attended the deceased from <u>7-28</u> <u>1952</u> , to <u>10-17</u> , <u>1952</u> , that I last saw the deceased alive on <u>10-17</u> , <u>1952</u> , and that death occurred at <u>12:45 Pm.</u> , from the causes and on the date stated above.	
23a. SIGNATURE Charles P. Fard		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 10-20-52		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 10/22/52		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE W. Boyd	
DATE REC'D BY LOCAL REG. OCT 21 1952		25. FUNERAL DIRECTOR'S ADDRESS 5304 Finney Ave	

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 *Lawrence E Woodson*

Licensed Embalmer No. *4341*

P. O. Address *St Louis 77/5*

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.