

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3297

S. No. 300
v. 10.48

FILED JAN 28 1953

State File No. _____

BIRTH NO. 80204 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0153

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>2189</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DOA Childrens Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>18 4546 Parkview avenue</u>		
3. NAME OF DECEASED (Type or Print)	a. (First) <u>Donald</u>	b. (Middle) <u>Lee</u>	c. (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-1-53</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>11-16-1952</u>	9. AGE (In years last birthday) (Specify) <u>6 weeks</u>	IF UNDER 1 YEAR: Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>William Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Lockhart</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm Johnson, 4546 Parkview</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Upper respiratory infection</u> <u>Pneumonia Bronchial</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) <u>Hemorrhage of Newborn?</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Several hours</u>
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>491X</u>			
22. I hereby certify that I attended the deceased from <u>12-29-52</u> to <u>12-31-52</u> , that I last saw the deceased alive on <u>12-31-52</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>[Signature]</u>			23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>1-5-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>1-1-53</u>	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Bolivar Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 7 1953</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Erwin-Blue F.H., Bolivar, Mo.</u>		

(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 *Dennis J. Jones*

Licensed Embalmer No. 4366

P. O. Address *Dennis J. Jones, MD*

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.