

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11776**
Registrar's No. **3275**

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		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY 2149	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Missouri)		c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 14 3630 CHILDRRESS	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) CATHERINE c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) MARCH 26, 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 20, 1874	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) IOWA	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME JAMES W. DENNIS	13b. MOTHER'S MAIDEN NAME ELIZABETH TOWNSEND	14. NAME OF HUSBAND OR WIFE THOMAS F. JOHNSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME CLARA MAE PEARSON	ADDRESS 3630 CHILDRRESS
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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, asthma, 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) Generalized Carcinomatosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. primary site undetermined		
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 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1999
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22. I hereby certify that I attended the deceased from **3-25-53**, 19___, to **3-26-53**, 19___, that I last saw the deceased alive on **3-26-53**, 19___, and that death occurred at **2:05P** m., from the causes and on the date stated above.

23a. SIGNATURE RM Higgins, M.D. (Degree or title) 0	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 3-27-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL (RAIL)	24b. DATE MAR. 27, 1953	24c. NAME OF CEMETERY OR CREMATORY ALBERT LEE, MINN.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. MAR 27 1953	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE KRIEGSHAUSER	ADDRESS 4228 SKINGSHIBAWAY
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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.....
Signature of Student Embalmer

Signed... *Richard W. Stoverson*

Licensed Embalmer No. *4007*

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.