

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15840**

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4048**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2259	
c. LENGTH OF STAY (in this place) 1 yr		d. STREET ADDRESS (If rural, give location) 25 1409 Carr St 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Elliott c. (Last) Johnson		4. DATE OF DEATH (Month) (Day) (Year) April 17 1953	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1878
9. AGE (In years last birthday) 75		10. KIND OF BUSINESS OR INDUSTRY Nil.	11. BIRTHPLACE (State or foreign country) Meridian, Miss,
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Bob Cooper		13b. MOTHER'S MAIDEN NAME Ella ?	14. NAME OF HUSBAND OR WIFE None
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Lee Johnson 3522 A, Clark Ave
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES DUE TO (b) Auricular Fibrillation Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Hypertensive Cardiovascular Disease 11. 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 CAUSATION	
19c. 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X
22. I hereby certify that I attended the deceased from 1-16 , 19 53 , to 4-17 , 19 53 , that I last saw the deceased alive on 4-17 , 19 53 , and that death occurred at 4:30a m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edna E. Brooks M. D.		23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 4-17-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE April 20, 1953	24c. NAME OF CEMETERY OR CREMATORY Leland Miss.	24d. LOCATION (City, town, or county) (State) Leland, Miss.
DATE REC'D BY LOCAL REG. APR 18 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wright Funeral Home 3100 Easton Ave.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.