

FILED DEC 4 - 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40649

State File No. \_\_\_\_\_  
Registrar's No. 11282

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

|   |  |   |                   |   |  |  |  |  |  |   |  |
|---|--|---|-------------------|---|--|--|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>318</u>   |                   | PRIMARY REG. DIST. NO. <u>1003</u>  |  | State File No. _____   |  | Registrar's No. <u>11282</u>   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>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 OR TOWN <u>St. Louis</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>   |  |   |                   | e. STREET ADDRESS (If rural, give location) <u>222 515 S. 23rd</u>  |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Cleo</u>   |  |   | b. (Middle) _____ |   |  | c. (Last) <u>Johnson</u>   |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>11 24 53</u> |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>Negro</u>   |                   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   |  | 8. DATE OF BIRTH <u>1-7-1907</u>   |  | 9. AGE (In years last birthday) <u>46</u>  |  | 10. UNDER 1 YEAR Days <u>11</u> Hours <u>17</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |  |   |                   | 10b. KIND OF BUSINESS OR INDUSTRY _____   |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Cleveland, Ohio</u>  |  |  | 12. CITIZEN OF WHAT COUNTRY? _____                       |   |  |
| 13a. FATHER'S NAME <u>William Johnson</u>   |  |   |                   | 13b. MOTHER'S MAIDEN NAME <u>Betty Montgomery</u>   |  |  |  | 14. NAME OF HUSBAND OR WIFE <u>Alma Johnson</u>                                  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____   |  |   |                   | 16. SOCIAL SECURITY NO. <u>495-16-6396</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME <u>William Henry Johnson</u> ADDRESS <u>515 S. 23rd</u>                              |  |  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*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>  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypernephroma with Metastasis</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br>INTERVAL BETWEEN ONSET AND DEATH <u>Undt.</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>180X</u>  |                   |   |  |  |  |  |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>9-9</u> , 19 <u>53</u> , to <u>11-24</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>11-24</u> , 19 <u>53</u> , and that death occurred at <u>9:00Am.</u> , from the causes and on the date stated above. |  |   |                   |   |  |  |  |  |  |   |  |
| 23a. SIGNATURE (Degree or title) <u>Beaunoir Prophete M.D.</u>  |  |   |                   | 23b. ADDRESS <u>2601 N. Whittier</u>  |  |  |  | 23c. DATE SIGNED <u>11/27/53</u>   |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____   |  | 24b. DATE <u>11-30-53</u>   |                   | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>   |  |  |  |   |  |
| DATE REC'D BY LOCAL REG. <u>NOV 30 1953</u>   |  | REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>  |                   |   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Jordan W. Chambers</u>   |  | ADDRESS <u>3100 Franklin</u>   |  |   |  |

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.....  
Signature of Student Embalmer

Signed *H. Claude Gordon*.....

Licensed Embalmer No. *348*.....

P. O. Address *4575 Rd*.....

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.