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FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13621**
Registrar's No. **3687**

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

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	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE Mem Hosp.		d. STREET ADDRESS (If rural, give location) 3063 MARCUS AVE	

3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) APR. 23, 1954
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED-NEVER-MARRIED, WIDOWED-DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT 29, 1887	9. AGE (In years last birthday) 66	IF ORDER IN YEARS Months Days	IF ORDER IN HOURS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY NAIL ENAMELING CO.	11. BIRTHPLACE (State or foreign country) BOSTON, MASS.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME PETER ROLUS KEVICH	13b. MOTHER'S MAIDEN NAME HELEN (UNKNOWN)	14. NAME OF HUSBAND OR WIFE VERONICA JOHNSON
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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. 33-03-3273	17. INFORMANT'S SIGNATURE OR NAME Mrs. Veronica Johnson	ADDRESS St. Louis, Mo.
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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, asthemia, 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) Pulmonary Embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 Strangulated hernia	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?
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22. I hereby certify that I attended the deceased from **4-22**, 1954, to **4/22**, 1954, that I last saw the deceased alive on **4/22**, 1954, and that death occurred at **10 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE J. J. Viggiel M.D. (Degree or title)	23b. ADDRESS 3511 University St. St. Louis, Mo.	23c. DATE SIGNED 4/23/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-22-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) East St. Louis Illinois
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DATE REC'D BY LOCAL REG. APR 23 1954	REGISTRAR'S SIGNATURE J. C. ...	25. FUNERAL DIRECTOR'S SIGNATURE ... ADDRESS St. Louis, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(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 _____

Licensed Embalmer No. 7541

P. O. Address East St. Louis, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.