

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20732**  
Registrar's No. **4873**

FILED JUN 24 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>217</b>	
b. CITY OR TOWN <b>St Louis</b>	c. LENGTH OF STAY (In this place) <b>0</b>	c. CITY OR TOWN <b>St Louis</b>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St Mary's Infirmary</b>		e. STREET ADDRESS (If rural, give location) <b>4034 Maffitt</b>	

3. NAME OF DECEASED a. (First) <b>Everlena</b> b. (Middle) _____ c. (Last) <b>Johnson</b>			4. DATE OF DEATH <b>5-30-54</b> (Month) (Day) (Year)		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6-1-1889</b>	9. AGE (In years last birthday) <b>64</b>	# UNDER 1 YEAR Days _____ # UNDER 1 HR. Mln. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>

13a. FATHER'S NAME <b>Alford Singleton</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Sadie Pope</b> ADDRESS <b>4034 Maffitt</b>
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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, asthenia, 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) <b>Cancer of Liver c Metastasis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. 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 _____	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) _____
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 _____

22. I hereby certify that I attended the deceased from **May 1954**, to **May 30, 1954**, that I last saw the deceased alive on **5/30**, 19**54** and that death occurred at **5:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Walter G. Young MD</b> (Degree or title) <b>0</b>	23b. ADDRESS <b>2337 Market</b>	23c. DATE SIGNED <b>6/1/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6-1-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Wynn Ark</b>
24d. LOCATION (City, town, or county) (State) _____		

DATE REC'D BY LOCAL REG. <b>JUN 1 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Ellis Funeral Home</b> ADDRESS <b>2820 Stoddard St.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Arthur E. Culkin*.....

Licensed Embalmer No. *419*.....

P. O. Address *Spokane*.....

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.