

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39514

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

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 543 Registrar's No. 2641

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits write "RURAL" and give township) <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2400 North Lind</u>		e. STREET ADDRESS (If rural, give location) <u>2400 North Lind</u>	
3. NAME OF DECEASED (Type or Print) <u>CAROLINE JOHNSON</u>			4. DATE OF DEATH <u>Nov. 13, 1954</u>
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Nov. 18, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Andrew Street</u>	
13b. MOTHER'S MAIDEN NAME <u>Caroline Debb</u>		13c. NAME OF HUSBAND OR WIFE <u>deceased</u>	
14. HAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-16-74980</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ruth Quinn</u>
17. ADDRESS <u>2400 North Lind</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Myocarditis</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 checked="" type="checkbox"/> NO <input 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) <u>4222</u>	
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 <u>September 1954</u> , to <u>November 1954</u> , that I last saw the deceased alive on <u>November 14, 1954</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>Thomas J. Summers, M.D.</u>		23b. ADDRESS <u>8200 Airport Road, Berkeley</u>	
23c. DATE SIGNED <u>11/15/54</u>		24. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE <u>Nov. 15, 1954</u>		24c. NAME OF CEMETERY OR CREMATOR <u>St. Matthews</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		25. GENERAL DIRECTOR'S SIGNATURE <u>Ruth Quinn</u>	
25. ADDRESS <u>1389 Union</u>		DATE REC'D BY LOCAL REG. <u>11/15/54</u>	

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 *Ben E. Hoffmann*
Licensed Embalmer No.....

P. O. Address *4366*.....

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.