

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27831

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7269**

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis | | c. CITY OR TOWN Webster Groves 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 Deaconess Hospital | | e. STREET ADDRESS (If rural, give location) 303 W. Jackson Rd. | |
| 3. NAME OF DECEASED (Type or Print) a. (First) WALDO b. (Middle) PATEN c. (Last) JOHNSON | | 4. DATE OF DEATH (Month) (Day) (Year) 8-19-1955 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 8-16-1882 |
| 9. AGE (In years last birthday) 73 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher | 11. BIRTHPLACE (City and State or Foreign Country) Maries Co. Mo. |
| 10b. KIND OF BUSINESS OR INDUSTRY Webster Pub. Co. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Calvin Johnson | | 13b. MOTHER'S MAIDEN NAME Mary J Creekpalm | |
| 13c. NAME OF HUSBAND OR WIFE Theresa Johnson | | 14. NAME OF HUSBAND OR WIFE Theresa Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 494-07-0619 | |
| 17. INFORMANT'S SIGNATURE OR NAME Mrs. W.P. Johnson | | ADDRESS 303 W Jackson Rd. | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Duodenal Ulcer | |
| INTERVAL BETWEEN ONSET AND DEATH 8 days | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| 19a. DATE OF OPERATION None | | 19b. MAJOR FINDINGS OF OPERATION -- | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. ACCIDENT SUICIDE HOMICIDE (Specify) No | |
| 21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) --- | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None | |
| 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 Aug. 10 , 19 55 , to Aug. 18 , 19 55 , that I last saw the deceased alive on Aug. 18 , 19 55 , and that death occurred at 1:00 a.m. , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE H. P. Goodrich, M.D. (Degree or title) | | 23b. ADDRESS 19 E. Lockwood Ave. Webster Groves (19) Mo. | |
| 23c. DATE SIGNED 8-19-55 | | 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | |
| 24b. DATE 8-22-1955 | | 24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | |
| 24d. LOCATION (City, town, or county) (State) Kirkwood Mo. | | 25. FUNERAL DIRECTOR'S SIGNATURE Walter F. Home Webster Groves Mo. | |
| DATE REC'D BY LOCAL REG. AUG 20 1955 | | REGISTRAR'S SIGNATURE J. Carl Smith (Licensed Embalmer's Statement on Reverse Side) | |

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

3281 13 140

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 *Neill D. Frohwitter*

Licensed Embalmer No. *369*
P. O. Address *15 W. Locke*

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.