No. 300
10.48

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

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31057

BIRTH NO. 60077-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8078

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. LOUIS CITY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY
c. CITY OR TOWN ST. LOUIS
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 3616 Vanal Av.

3. NAME OF DECEASED (Type or Print)
a. (First) DELORES
b. (Middle)
c. (Last) JOHNSON

4. DATE OF DEATH (Month) JULY (Day) 7 (Year) 1955

5. SEX FEMALE
6. COLOR OR RACE NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH JULY 6, 1955
9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 11 Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME J. B. JOHNSON
13b. MOTHER'S MAIDEN NAME MARY
14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME HOSPITAL RECORD ADDRESS

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 9 hours

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 776 X
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6-55, *19*____, *to* 7-7-55, *19*____, *that I last saw the deceased alive on* 7-7-55, *19*____, *and that death occurred at* 2:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE Leon B. Klein (Degree or title) M.D.
23b. ADDRESS 1515 Lafayette Avenue
23c. DATE SIGNED 7-7-55

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 9-30-55
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) St. Louis, Mo. (State)

DATE REC'D BY LOCAL REG. SEP 14 1955
REGISTRAR'S SIGNATURE J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS 2110 Rochester Ave. St. Louis 10, Mo.

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.