

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38419

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10602**

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 township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital		STREET ADDRESS 2/ 926 North 22nd		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 1	

3. NAME OF DECEASED (Type or Print) a. (First) Daisy b. (Middle) c. (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) 11 29 55		
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Oct. 7, 1900		9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months 1 Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Sie Jackson		13b. MOTHER'S MAIDEN NAME Mae Francis Malone		14. NAME OF HUSBAND OR WIFE Roosevelt Johnson	
---------------------------------------	--	---	--	--	--

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. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sie Jackson 701 Ave J. Greenville, Miss	
--	--	-----------------------------------	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriolar nephrosclerosis with Uremia						Undt.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 446X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 **11-27**, 19**55**, to **11-29**, 19**55**, that I last saw the deceased alive on **11-29**, 19**55**, and that death occurred at **4:55 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 11-30-55	
--	--	--------------------------------------	--	----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec 6 1955		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo	
--	--	-----------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. DEC 5 1955		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 Bell Ave.	
--	--	--	--	---	--

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

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 *A. J. Watson*.....

Licensed Embalmer No. *269*.....

P. O. Address *2769 N. ...*.....

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.