FILED FEB 21 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6550

STATE FILE NUMBER 639

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

Health, Welfare Public Service

300 0
1-56

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 09 DePaul Hospital Length of stay in Ib 30 Mins,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Pine Lawn, 27 4000 0 Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 4278 Brandywine Ct. Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First Fred Middle Last Johnson

4. DATE OF DEATH Month Day Year Jan. 20, 1957

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 30, 1904
9. AGE (In years last birthday) 52
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker
10b. KIND OF BUSINESS OR INDUSTRY Goverment Housing
11. BIRTHPLACE (City and state or country) Missouri. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Johnson
14. MOTHER'S MAIDEN NAME Cora Holshauser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Raymond Johnson, 6804 Wise Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma & Lung — INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 163X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 27, 1956 to Jan. 20, 57 and last saw him alive on Jan 16, 57
Death occurred at Jan 20, 57 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title) Wesley E. Hauck M.D.
22b. ADDRESS 9700 Lucas & Hunt Blvd
22c. DATE SIGNED Jan. 21, 57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-20-57
23c. NAME OF CEMETERY OR CREMATORY Essex Cemetery
23d. LOCATION (City, town, or county) (State) Essex, Missouri.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,
25. DATE RECD. BY LOCAL REG. JAN 21 '57
26. REGISTRAR'S SIGNATURE J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 21 1957

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... G. W. Wilkinson

Licensed Embalmer No. 35

P. O. Address M. Ro

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