

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

14859

FILED APR 26 1957

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

3592

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. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 01 3218a North Taylor		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) c. (Last) Johnson, Jr.		4. DATE OF DEATH (Month) (Day) (Year) April 13, 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 2/2/56
9. AGE (In years last birthday) 1 2		10. IF UNDER 18 yrs. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Albert Johnson		13b. MOTHER'S MAIDEN NAME Lillian Holloway	
14. NAME OF HUSBAND OR WIFE none		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. none		17. INFORMANT'S SIGNATURE OR NAME Albert Johnson, 3218a N. Taylor	
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 INTERSTITIAL PNEUMONITIS 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	
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)	
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 _____ 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:22 P.M., from the causes and on the date stated above.			
23a. SIGNATURE <i>Charles J. Gates</i>		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 4/10/57		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 4/18/57		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 4107 Finney Ave.	
DATE REC'D BY LOCAL REG. APR 15 '57		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

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..... *Erufon Swan*

Licensed Embalmer No. 4586

P. O. Address 4107 Finney

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.