

SL 18028

THE DIVISION OF HEALTH OF MISSOURI

14861

XC-528 430 FILED APR 22 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

318

1003

3300

Registration District No.

Primary Registration District

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST. CLAIR				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN E. ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			Length of stay in 1b 7 days		d. STREET ADDRESS (If outside, give location) 1407 S. "E" ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLEY JOHNSON				4. DATE OF DEATH APRIL 2, 1957				
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/00		
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (City and state or country) BOLIVAR, TENN.				12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME CHARLEY JOHNSON				14. MOTHER'S MAIDEN NAME MARTHA LANG				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) YES		16. SOCIAL SECURITY NO. 350-03-3666		17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC INSUFFICIENCY							INTERVAL BETWEEN ONSET AND DEATH UNK.	
Conditions, if any, which gave rise to above cause (a): DUE TO (b) AORTIC VALVULAR INSUFFICIENCY							UNK.	
DUE TO (c) LUETIC HEART DISEASE							UNK.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - - - - 023x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) VA		20f. CITY, TOWN, OR LOCATION VAH, ST. LOUIS, MO.		COUNTY		STATE		
21. Attended the deceased from 3/26/57 to 4/2/57 and last saw him alive on 4/2/57 Death occurred at 6:28 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Name or title) [Signature] M.D.				22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 4/2/57		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY S. T. KAMINSKAS M. D. National Cem		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.		
24. FUNERAL DIRECTOR R.M.C. Green, 4060 Washington			25. DATE RECD. BY LOCAL REG. APR 5 '57		26. REGISTRAR'S SIGNATURE [Signature]			

(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

300
1-56Health,
& Welfare
Public
Service

Securing the medical certification in the specific manner required by the laws of the State of Missouri is the responsibility of the registrars.

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NAME OF

DECEASED

X

DATE OF DEATH

PLACE OF DEATH

X

DATE OF BURIAL

PLACE OF BURIAL

PREPARED BY

ADDRESS

CITY

OR

STATE

COUNTY

ZIP

AGE

SEX

RELATIONSHIP

CAUSE OF DEATH

DATE OF DEATH

STATE OF TEXAS

DATE

BY

STATEMENT BY LICENSED EMBALMER

YOUR SIGNATURE IS NECESSARY TO SIGNIFY

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 *Melvin E. Green*

Licensed Embalmer No. *44*

P. O. Address *St. Louis*

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.

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