

FILED JUL 31 1957

STANDARD CERTIFICATE OF DEATH

26234
STATE FILE NUMBER
6730
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

300
1-56

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>27 Homer G. Phillips Hospital</u>		Length of stay in lb <u>3 yrs.</u>	STREET ADDRESS <u>220 1612 Elliott</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>J.</u> Last <u>JOHNSON</u>			4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/1926</u>	9. AGE (In years last birthday) <u>31</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>	11. BIRTHPLACE (City and state or country) <u>Marvel, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Dave Johnson</u>			14. MOTHER'S MAIDEN NAME <u>Emma Wiley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Navy W. W. II</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Dave Johnson</u> Address <u>1612 Elliott</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>(Non traumatic)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. --(Enter nature of injury in Part I or Part II of item 18.) <u>465x</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>7:55 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.</u>					
22a. SIGNATURE <u>Dr. J. E. Smith</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>7/19/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/9/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Charles J. Gates</u>		ADDRESS <u>4107 Finney</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 19 57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>M. J. B.</u>

(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. 450

P. O. Address 4107 Fin

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.