

Health, Welfare, Public Service

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1957

318

1003

26236
STATE FILE NUMBER

6397
Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>OVERLAND PARK</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>JEWISH HOSP.</u>		Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>27 2472 BROWN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>WALLACE</u> First Middle Last <u>JOHNSON</u>			4. DATE OF DEATH Month <u>7</u> Day <u>8</u> Year <u>57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 16 1883</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAIL MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. POSTAL</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JOHNSON</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MINA JOHNSON 2472 BROWN</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>Acute Coronary Occlusion with myocardial Infarction - Atherosclerosis,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>+ 1 day</u> <u>unknown</u>	
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.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>5/27/57</u> to time of death and last saw her alive on <u>7/8/57</u> Death occurred at <u>120 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Alfred Fleishman MD</u>			22b. ADDRESS <u>2560A Woodson Rd Overland MO</u>		22c. DATE SIGNED <u>7/9/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL</u>		23d. LOCATION (City, town, or county) (State) <u>Kirkwood Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>EARL HIGGEMAN 9709 LAGLAND</u>			25. DATE RECD. BY LOCAL REG. <u>JUL 10 57</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith MD - mgb.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Carl E. Hillman*

Licensed Embalmer No. *350*

P. O. Address *Orland*

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.