

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29604

STATE FILE NUMBER

FILED SEP 4 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8048**

| | | | | | |
|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4427 Wilcox | | Length of stay in lb | d. STREET ADDRESS 4427 Wilcox | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) DESSIE LEON JOHNSON | | | First | Middle | Last |
| 4. DATE OF DEATH 8 27 1957 | | | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-9-1885 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (City and state or country) Galena, Kansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Brown | | | 14. MOTHER'S MAIDEN NAME Zetta Tipton | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Harvey Johnson, 4427 Wilcox | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Cervix | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | DUE TO: (b) 171x |
| DUE TO: (c) | | | | | |
| 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 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 Month, Day, Year a. m. p. m. | | | | | |
| 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 July 4, 1957 to August 27, 1957 and last saw her: alive on August 26, 1957 Death occurred at 12 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Thomas J. Summers, M.D. (Degree or title) | | | 22b. ADDRESS 3857 Luddell St. Louis 8, Mo. | | 22c. DATE SIGNED 8-28-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) | | |
| Removal | 8-29-1957 | St. Trinity Cemetery | St. Louis Co., Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette | | 25. DATE RECD. BY LOCAL REG. AUG 28 57 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P | | |

Dr Thomas Summers
Russell & Compton

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.....
P. O. Address.....

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.