

Health, & Welfare
Public Service
300
-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

FILED NOV 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42873

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 541 Registrar's No. 2821

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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 <u>Clayton</u> TOWN		c. CITY OR TOWN <u>Overland 423X</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. E. Co. Hospital</u>		Length of stay in lb <u>12 days</u>	
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</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>Jan. 24, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>80</u>
13. FATHER'S NAME <u>Joseph Rhodes</u>		11. BIRTHPLACE (City and state or country) <u>Evansville, Indiana</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Ann Blackburn</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charles W. Johnson, 9118 Delphine</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>Arteriosclerotic Heart Disease with congestive failure.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>United Hernia - Post operative</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>11-4-57</u> to <u>11-16-57</u> and last saw her ^{her} _{him} alive on <u>11-16-57</u> Death occurred at <u>2:05</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Richard H. King M.D.</u>		22b. ADDRESS <u>601 S. Brentwood Clayton 5, MO.</u>	
22c. DATE SIGNED _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-18-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fee Fee Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pattonville, Missouri</u>	
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u> 2504 Woodson Rd., Overland, Mo.		25. DATE RECD. BY LOCAL REG. <u>11-17-57</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert R. Donkey M.D.</u>			

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 *David C. Gilbr...*

Licensed Embalmer No. *340*

P. O. Address *Coarland*

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.