

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013021
STATE FILE NUMBER

FILED APR 9 1958

Registration District No. 372 Primary Registration District No. 6264 Registrar's No. 8

300
1-57

1120

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>WEBSTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HAZELWOOD TOWNSHIP</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>SEYMOUR</u> <u>1120</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 Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>CARRIE CAROLINE JOHNSON</u>			4. DATE OF DEATH Month Day Year <u>3 - 29 - 58</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 13, 1895</u>
9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>STATE OF INDIANA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JAMES A. SHORT</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN C. MCCLAIN</u>	14. NAME OF HUSBAND OR WIFE <u>CLARENCE JOHNSON</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>MRS. MABEL YARGER SEYMOUR, Mo. R.T.L.</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>B. Lateral Hydrocephalus & Ureteral Obstruction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>Epidermoid Carcinoma of Cervix Uteri.</u> DUE TO (c) <u>171X</u> 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 <u>1 YR.</u>
19. WAS AUTOPSY PERFORMED? <u>NO</u>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>March 1 - 57</u> , to <u>3/29/58</u> and last saw ^(her) <u>him</u> alive on <u>3/28 - 58</u> Death occurred at <u>11:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. A. Gill</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Seymour</u>	22c. DATE SIGNED <u>4/5/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-1-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>WRIGHT & MT. GROVE, Mo.</u>
24. FUNERAL DIRECTOR <u>Robert Bergman</u> ADDRESS <u>Seymour Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-7-1958</u>	26. REGISTRAR'S SIGNATURE <u>Gilbert Jones</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 *Max S. Miller*

Licensed Embalmer No. *4720*
P. O. Address *Marshall Mo*

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.