

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023957

STATE FILE NUMBER

FILED JUL 11 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1615

300
1-57
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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Brentwood 4511	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp. D.O.A.		d. STREET ADDRESS (If outside, give location) 2948 Brentwood Blvd.	
3. NAME OF DECEASED (Type or print) First EDNA Middle IRENE Last JOHNSON		4. DATE OF DEATH Month June Day 14 Year 1958	
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 Oct. 28, 1900
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Peter Auer	
13b. MOTHER'S MAIDEN NAME Julia Brandt		14. NAME OF HUSBAND OR WIFE Andrew B. Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <input type="checkbox"/> (If yes, give dates of service) None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Andrew B. Johnson 2948 Brentwood
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			422.2
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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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. _____	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 Oct. 1957 to _____ and last saw her/him alive on ? Death occurred at 7:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Please print name) <i>[Signature]</i>		22b. ADDRESS 4930 Lindell Blvd.,	22c. DATE SIGNED 6-16-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 18, 1958	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser	ADDRESS 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. 6-16-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

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 *William B. White*

Licensed Embalmer No. *4291*

P. O. Address

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.