

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026565
STATE FILE NUMBER

57919-57
FILED AUG 11 1958 Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 123

1. PLACE OF DEATH a. COUNTY Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Fort Leonard Wood		0 850 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital			Length of stay in lb --		d. STREET ADDRESS (If outside, give location) US Army Hospital		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOSEPH Middle WILLIE Last JOHNSON JR				4. DATE OF DEATH Month July Day 30 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 July 1958		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 0 Days 0 Hours 0 IF UNDER 24 HRS. Mn. 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Willie Johnson, Sr				14. MOTHER'S MAIDEN NAME Naomi Best			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT B S WYSOCKI Maj MSC Address US Army Hosp Ft Leonard Wood, Mo			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Pulmonary atresia Congenital Heart Disease. Tricuspid stenosis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Large interauricular septal defect. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
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.) 7543				
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		COUNTRY STATE	
21. I attended the deceased from 30 July 1958 to 30 July 1958 and last saw him alive on 30 Jul 58 Death occurred at 10:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or Print) Benjamin Post Mc				22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri		22c. DATE SIGNED 30 Jul 58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		August 1 1958		Post Cemetery		Ft Leonard Wood Missouri	
24. FUNERAL DIRECTOR OR ADDRESS HEDGES FUNERAL HOMES INC CROCKER MO 7-31-58				25. DATE RECD. BY LOCAL REG. 7-31-58		26. REGISTRAR'S SIGNATURE Carl Gray Anderson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Health 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.

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 *Clarence J. Moss*.....

Licensed Embalmer No. *4896*

P. O. Address *Waynesville*

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..