

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045867
STATE FILE NUMBER
11770

318

1003

FILED DEC 22 1958

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2219 1813 Franklin	
3. NAME OF DECEASED (Type or print) First Josh Middle Johnson Last Johnson		4. DATE OF DEATH Month 12 Day 4 Year 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		11. BIRTHPLACE (City and state or country) Wayside, Miss.	
13a. FATHER'S NAME Billy Johnson		14. NAME OF HUSBAND OR WIFE nil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W.W.I		17. INFORMANT Alpha Turner	
16. SOCIAL SECURITY NO.		Address 1813 Franklin Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Atherosclerosis DUE TO (c) 332X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sacral Decubiti			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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 11-12-58 , to 12-4-58 and last saw ^{xxx} him alive on 12-4-58 Death occurred at 9:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. G. Traver, M.D.		22b. ADDRESS 2601 Whittier Street	
		22c. DATE SIGNED 12-5-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 12-9-58	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR Dement & Son		25. DATE RECD. BY LOCAL REG. DEC 8 58	
ADDRESS 2629-31 Cole St.		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. M. J. B.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by, Student Embalmer No.
working under my personal supervision.

Student

Signature of Student Embalmer

Signed

H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alder

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.