Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003727
STATE FILE NUMBER

FEB 10 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 294

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Clayton — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hosp. — Length of stay in lb 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Webster Groves 4000 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 109 Willis — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Middle Last: Baby Girl "B" Johnson

4. DATE OF DEATH Month Day Year: 1 - 18 - 59

5. SEX: female 3

6. COLOR OR RACE: negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-17-59

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days: 1 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (City and state or country): Clayton, Mo. USA

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Amah Johnson

13b. MOTHER'S MAIDEN NAME: Mary Lee Sheppard

14. NAME OF HUSBAND OR WIFE: none

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.: none

17. INFORMANT Address: St. Louis County Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IMMATURITY (850 grams) — INTERVAL BETWEEN ONSET AND DEATH: From Birth
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 77[illegible]

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐ 1

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Jan 17-'59, to Jan 18-'59 and last saw her/him alive on Jan. 18-1959
Death occurred at 3 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Leo F Gowen MD

22b. ADDRESS: 601 S. Brentwood

22c. DATE SIGNED: 1-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: 1-30-59

23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: County Hospital, Clayton

25. DATE RECD. BY LOCAL REG.: 1-30-59

26. REGISTRAR'S SIGNATURE: John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be [illegible]
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 by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed .....

Licensed Embalmer No.....

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.