Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-003778
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 317 Primary Registration District No. 542 Registrar's No. 131

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Ferguson — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Oak Knoll Home — Length of stay in 1b MONS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY ST LOUIS
c. CITY OR TOWN University City 4606 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 8121 Kingsbury — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Emma Middle Belle Last Johns
4. DATE OF DEATH Month 1 Day 12 Year 1959
5. SEX Female
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 9-4-1876
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (City and state or country) Jefferson Co. Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Joshua Cole
13b. MOTHER'S MAIDEN NAME Ann Long
14. NAME OF HUSBAND OR WIFE Wm. Leslie Johns
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. - -
17. INFORMANT Delos C. Johns, Address St. Louis, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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) Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardio-vascular disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Old left hemiplegia 4221
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 Dec 30, 1957, to Jan 12, 1959 and last saw her alive on Jan 6, 1959
Death occurred at 2:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Lewis Lillmann MD (Degree or title)
22b. ADDRESS 8231 Clayton Rd (17)
22c. DATE SIGNED 1/13/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1-14-1959
23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery
23d. LOCATION (City, town, or county) Farmington, (State) Mo.

24. FUNERAL DIRECTOR White-Mullen ADDRESS Ferguson 21, Mo.
25. DATE RECD. BY LOCAL REG. 1-13-59
26. REGISTRAR'S SIGNATURE John C. Murphy MD

(Licensed Embalmer's Statement on Reverse Side)

## 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 Reinhold K. Lohrmann

Licensed Embalmer No. 3395

P. O. Address Ferguson 21 M

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.