

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003806

STATE FILE NUMBER

FIFED JAN 26 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 168

300
-57 1

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE MO b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirkwood 4673	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1024 Curran	Length of stay in lb 3 mo	d. STREET ADDRESS (If outside, give location) 1008 N Woodlawn	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ruth Middle B Last Johnson	4. DATE OF DEATH Month Jan Day 17 Year 1959
--	--

5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/1879	9. AGE (In years last birthday) 79	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) retired cafeteria work	10b. KIND OF BUSINESS OR INDUSTRY St. L. School Board	11. BIRTHPLACE (City and state or country) Mounds City Ills 1	12. CITIZEN OF WHAT COUNTRY? US
---	--	--	------------------------------------

13a. FATHER'S NAME Wm Painter	13b. MOTHER'S MAIDEN NAME Anna M Kennedy	14. NAME OF HUSBAND OR WIFE Thos H, I. Johnson Sr
----------------------------------	---	--

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. unk.	17. INFORMANT Thos H, I. Johnson Jr	Address 1024 Curran Kirkwood
---	---------------------------------	--	---------------------------------

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 36 hrs. 2 1/2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Thrombosis	
	DUE TO (c) Generalized Arterio sclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x		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 1957 to 1-16-59 and last saw her alive on 1-16-59 Death occurred at 8:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Norman C. Ross M.D.	22b. ADDRESS 1695 Brentwood Blvd	22c. DATE SIGNED 1-15-59
---	-------------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/19/59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo
---	----------------------	---	--

24. FUNERAL DIRECTOR Louis H Bopp Inc ADDRESS Kirkwood	25. DATE REC'D. BY LOCAL REG. 1-18-59	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
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 by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed, *Francis J. Magendie*
Licensed Embalmer No. *4512*
P. O. Address *Kirkwood, Mo.*

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.