Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003867
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Richmond Heights — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Maplewood 4524 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Mary's Hospital — Length of stay in lb 30 Hrs.	d. STREET ADDRESS (If outside, give location) 2551 Big Bend Blvd. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: CAROL	Middle: LYNNE	Last: JOHNSON	4. DATE OF DEATH Month Day Year: Jan. 7, 1959
5. SEX: F	6. COLOR OR RACE: W	7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 1-5-1959
9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours 30 / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nil	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (City and state or country): St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Ronald Johnson	13b. MOTHER'S MAIDEN NAME: Nora Smith	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)	16. SOCIAL SECURITY NO.	17. INFORMANT: Ronald Johnson, Address above	

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) Anoxia of Brain — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Pneumonia - Meconium — 24 hrs

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1630

19. WAS AUTOPSY PERFORMED? YES [X] 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 1/5/59, to 1/7/59 and last saw her/him alive on 1/7/59
Death occurred at 2:30 a.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): James L. Danahoe MD	22b. ADDRESS: 950 Francis Pl. St. Louis, Mo.	22c. DATE SIGNED: 1-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 1-8-59	23c. NAME OF CEMETERY OR CREMATORY: Lake Charles Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS: JAY B. SMITH, Maplewood, Mo.	25. DATE RECD. BY LOCAL REG.: 1-8-59	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

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 Not embalmed, Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed H P Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.