

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011061

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2471**

300
1-57
28
3
0

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, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4004 Delmar Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester Johnson			4. DATE OF DEATH Month Day Year March 8, 1959
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 Nov. 22, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 56 Months Days Hours Min. 70
11. BIRTHPLACE (City and state or country) Missouri Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Charles Johnson		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lillie Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Lillie Johnson 4004 Delmar Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung 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) 163x			INTERVAL BETWEEN ONSET AND DEATH
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.) ITEM 8, 9, 11 5-28-59 CORRECTED	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		BY: 1. AFFIDAVIT OF Funeral Director 2. DOCUMENT Records Bd. of Election Comm. St. Louis 69-3-1946	
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 _____ and last saw her/him alive on _____ Death occurred at 248A on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Calvin E. Myler		22b. ADDRESS 1300 Clara	22c. DATE SIGNED 2/11/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/12/59	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri
24. FUNERAL DIRECTOR ADDRESS G. Wade Granberry 4202 Finney Avenue		25. DATE RECD. BY LOCAL REG. MAR 11 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>m.g.B</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Edward G Flynn*

Licensed Embalmer No. ~~4444~~.....
P. O. Address 4202 Finney Ave....

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.