

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011064

STATE FILE NUMBER

2 1791

REG. MAR 18 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>AFTON 4820</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP. #1.</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>9437 UPLAND</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>T HIRZAH JOHNSTON</i>			4. DATE OF DEATH Month Day Year <i>FEB. 17, 1959</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 25, 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AT HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>74</i> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <i>INDIANA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>FRANK HOLMAN</i>		13b. MOTHER'S MAIDEN NAME <i>MARY PHILLIPS</i>	14. NAME OF HUSBAND OR WIFE <i>DECEASED</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>490-18-9671</i>	17. INFORMANT Address <i>IPHIA ROLL 9437 UPLAND</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>330x</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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 <i>2/5/59</i> to <i>2/17/59</i> and last saw her/him alive on <i>2/17/59</i> Death occurred at <i>12:10 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>D. Johnson M.D.</i> (Degree or title)		22b. ADDRESS <i>1515 LA FAYETTE A VE</i>	22c. DATE SIGNED <i>2/17/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>2/20/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>VALHALLA CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS CO., MO.</i>
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN &amp; SONS</i> ADDRESS <i>7027 GRAVOIS</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 19 59</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

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 *Donald E. Perry* .....

Licensed Embalmer No. *4803* .....

P. O. Address *7021* .....

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.