

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023049

STATE FILE NUMBER
26002

FILED JUL 7 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
1-57
P
95

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		Inside Limits Yes <input 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) 1529 Webster Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Virgil Middle Last Johnson			4. DATE OF DEATH Month 6 Day 19 Year 59		
---	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-59	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Hours 15
--------------------	-------------------------------	---	---------------------------------	---------------------------------	--------------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	---	---

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME Anna Johnson	14. NAME OF HUSBAND OR WIFE
--------------------	---	-----------------------------

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. none	17. INFORMANT Homer Phillips Address 2601 N. Whittier
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth, Neonatal death		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	773.5
	DUE TO (c)	
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? NO 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 6-19-59 to 6-19-59 and last saw him alive on 6-19-59 Death occurred at 10:10 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Park White, M.D. (Degree or title)	22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 6-22-59
--	--------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) 6-30-59	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
--	-----------	--	---

24. FUNERAL DIRECTOR Roulandker 4104 Manchester ADDRESS	25. DATE RECD. BY LOCAL REG. JUN 25 '59	26. REGISTRAR'S SIGNATURE M. B. Leonard Smith, M.D.
--	--	--

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

Licensed Embalmer No.....

P. O. Address.....

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.