

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023725

STATE FILE NUMBER

FILED JUN 26 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1629

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Manchester Nursing</b>			Length of stay in 1b <b>3 years</b>		d. STREET ADDRESS (If outside, give location) <b>4021a W. Florissant</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Home</b> Middle <b>Charles</b> Last <b>Johnson</b> <b>CHARLES CHARLES ELBERT JAMES JOHNSON</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1959</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 26, 1883</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <b>Retired - Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fix Material Co.</b>		11. BIRTHPLACE (City and state or country) <b>Covington, Kentucky</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Tandy Johnson</b>				13b. MOTHER'S MAIDEN NAME <b>Elizabeth Utz</b>				14. NAME OF HUSBAND OR WIFE <b>Estelle Johnson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>496-12-7768</b>		17. INFORMANT Address <b>Mrs. Estelle Johnson - 4021a W. Florissant</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC SUPPURATIVE BRONCHITIS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>?</b>				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CARDIO-VASCULAR DISEASE</b>								<b>?</b>				
DUE TO (c) <b>NONE</b>								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 a.m. p.m. Month, Day, Year												
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 <b>MAY 8, 1959</b> to <b>JUNE 16, 1959</b> and last saw <input checked="" type="checkbox"/> him alive on <b>JUNE 16, 1959</b> Death occurred at <b>6:20 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <b>B. R. Loving, M.D.</b>						22b. ADDRESS <b>BALLWIN, MO.</b>			22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>June 19, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>						25. DATE RECD. BY LOCAL REG. <b>6-17-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy</b>				

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 *Clement M. Neary*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.