

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030520

FILED VS AUG 31 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7503** STATE FILE NUMBER

INDEXED

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|---|--|---|---|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> | | Length of stay in 1b | | c. CITY OR TOWN <u>Overland</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>2944 Poe</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>GILBERT W. JOHNSON</u> | | | | 4. DATE OF DEATH Month <u>AUGUST</u> Day <u>11</u> Year <u>1959</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-7-1922</u> | | 9. AGE (last birthday) <u>36</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u> | | 11. BIRTHPLACE (City and state or country) <u>Arkansas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>Andrew Johnson</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Rapert</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Evelyn Johnson</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u> | | | | 16. SOCIAL SECURITY NO. <u>Unk.</u> | | 17. INFORMANT <u>Evelyn Johnson, Overland, Mo.</u> <u>2944 Poe</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>ACUTE HEPATIC FAILURE</u> | | | | | | | | | | <u>1 WEEK</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO (b) <u>BRONCHOGENIC CARCINOMA WITH METASTASES</u> | | <u>3 MONTHS</u> | |
| DUE TO (c) _____ | | | | | | | | | | <u>162.1</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <u>MAY 15, 1959</u> to <u>AUGUST 11, 1959</u> and last saw her/him alive on <u>AUGUST 11, 1959</u> Death occurred at <u>12:15 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Harold J. Joseph</u> (Degree or title) <u>M. D.</u> | | | | | | 22b. ADDRESS <u>BARNES HOSPITAL</u> | | | | 22c. DATE SIGNED <u>8/11/59</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>8-11-1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Local</u> | | 23d. LOCATION (City, town, or county) (State) <u>Corning, Arkansas</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Russell-Ermert, Corning, Ark.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>AUG 12 '59</u> | | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>mjb</u> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence M. Billa

Licensed Embalmer No. 4375

P.O. Address St. Louis, 23 Mo.

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.