

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037737

FILED VS NOV 6 1959

2 9740

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>Hornersville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glemon Memorial Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Route 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Hubert</b> Middle <b>W</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-16-59</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>		IF UNDER 24 HR Hours <b>5</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hornersville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>Elmer Johnson</b>			13b. MOTHER'S MAIDEN NAME <b>Josie Marie Wilson</b>			14. NAME OF HUSBAND OR WIFE <b>None</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>None</b>		17. INFORMANT <b>Elmer Johnson, Hornersville, Mo.</b> Address				
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>Aspiria secondary to massive dilat. pneumonia.</b> DUE TO (b) <b>Aspiration from Tracheo-oesophageal fistula congenital.</b> <del>Other</del> (c) <b>Multiple congenital anomalies (cf part II)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal illness (condition listed in PART I (a)) <b>Deceased under medical care. Immediate cause, absent L. kidney, cleft palate, Pharyngitis</b>					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.) <b>756.2</b>					
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 <b>10-17-59</b> , to <b>10-21-59</b> and last saw her/him alive on <b>10-21-59</b> Death occurred at <b>9:45</b> <b>P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Charles A. High, MD</b>				22b. ADDRESS <b>1465 S. Grand.</b>		22c. DATE SIGNED <b>10-22-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-23-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hornersville, Mo.</b>					
24. FUNERAL DIRECTOR <b>Emerson Funeral Home, Hornersville, Mo.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>OCT 23 1959</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b> <b>S.P.</b>		

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 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.