URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042042

FILED VS NOV 20 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210198 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Lukes Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Dent
c. CITY OR TOWN: Salem
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): R.Rt. 5
Reside on Farm: Yes ☒ No ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle RYRIE Last JOHNSON
4. DATE OF DEATH: Month Nov Day 5th Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3/13/1891
9. AGE (last birthday): 68
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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: farmer
11. BIRTHPLACE (City and state or country): St.Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: George T. Johnson.
13b. MOTHER'S MAIDEN NAME: Helen Forbes.
14. NAME OF HUSBAND OR WIFE: Estelle Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs.Robert Johnson. Address: Salem, Missouri.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal obstruction
Conditions which gave rise to above cause (a), stating the underlying cause last — DUE TO (b): Metastatic Adenocarcinoma
DUE TO (c): Adenocarcinoma of Lt. Colon
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 153-2

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 11/4/59, to 11/5/59 and last saw her/him alive on 11/5/59.
Death occurred at 2:30 Am 11/5/59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James A. Freeman (Degree or title) MD
22b. ADDRESS: 5635 Delmar
22c. DATE SIGNED: 11/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 11/7/59
23c. NAME OF CEMETERY OR CREMATORY: Bellefontaine Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Missouri

24. FUNERAL DIRECTOR: C. R. Lupton and sons ADDRESS: 7233 Delmar Blvd
25. DATE RECD. BY LOCAL REG.: NOV 6 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

VS NOV 20 1959

FEB 2 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Arnold W. Schoene

Signature of Student Embalmer

Licensed Embalmer No. 3864

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.