

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 15 1960

212019 '59 045603 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1		d. STREET ADDRESS (If outside, give location) 2905 South 18th Street.	

3. NAME OF DECEASED (Type or print) First Middle Last ISOM T. JOHNSON			4. DATE OF DEATH Month Day Year Dec. 26, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/3/1901	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner Man	10b. KIND OF BUSINESS OR INDUSTRY Hussman Refrigerator	11. BIRTHPLACE (City and state or country) Black Oak, Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Albert Johnson	13b. MOTHER'S MAIDEN NAME Unavailable	14. NAME OF HUSBAND OR WIFE Verdie Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I	16. SOCIAL SECURITY NO. 431-09-4656	17. INFORMANT Address Marion Lindsay, 2905 South 18th Street.
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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) CEREBRAL HEMORRHAGE		20 MIN
DUE TO (b) CEREBRAL VASCULAR		
DUE TO (c) ARTERIOSELEROSIS		YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x		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
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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.)
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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
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21. I attended the deceased from 12/21/59 to 12/26/59 and last saw him alive on 12/26/59 Death occurred at 9:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Nicholas Owen M.D.	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 12/26/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/27/1959	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Monett, Arkansas.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington	25. DATE RECD. BY LOCAL REG. DEC 27 1959	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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71. 8.03.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley P. DePa

Licensed Embalmer No. 4192

P. O. Address So. Lansing

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