

FEDERAL BUREAU OF INVESTIGATION FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 18 1960

212081-59-046988

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) _____ OR TOWN <u>St. Louis</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) _____ HOSPITAL OR INSTITUTION <u>St. John's Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Richmond Heights</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>812 S. Hanley</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
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3. NAME OF DECEASED (Type or print) First <u>LEONORA</u> Middle <u>JOHNSON</u> Last _____			4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1881</u>	9. AGE (last birthday) <u>78</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maries Co., Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unk. Love</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wilhite</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel C. Johnson</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Richmond Heights</u> <u>James M. Johnson 1157 Center Dr.</u>
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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: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>420.1</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)		
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 1951</u> to <u>Dec 1959</u> and last saw her <u>Dec 27, 1959</u> alive on <u>11 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Walter W. Davis, M.D.</u>	22b. ADDRESS <u>529 N. Grand</u>	22c. DATE SIGNED <u>12/29/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/31/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>C.R. Lupton & Sons 7233 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 29 1959</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> S.P.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

4-4980

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 Clarence H Murray

Licensed Embalmer No. 4011

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.