RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

-60-008424

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1728

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO.
Length of stay in 1b: LIFE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MASONIC HOME HOSPITAL
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5351 DELMAR
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First MAE (MRS.) Middle Last JOHNSON
4. DATE OF DEATH: Month 2// Day I2 Year ///I96 0
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/7/1882
9. AGE (last birthday): 77
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (City and state or country): ST.LOUIS,MO.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: HENRY M. BEADLE
13b. MOTHER'S MAIDEN NAME: ELMIRA BROWN
14. NAME OF HUSBAND OR WIFE: CLAUDE E.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Masonic Home Address: 5351 Delmar Blvd.

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)	ACUTE MYOCARDIAL INFARCTION	1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE	15 MOS
DUE TO (c)	ARTERIOSCLEROSIS, GENERALIZED	15 MOS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
AUG 1958
CEREBRAL VASCULAR ACCIDENT WITH RIGHT HEMIPLEGIA

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.)
420.0
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 10/29/58, to 2/12/60 and last saw her alive on 2/12/60
Death occurred at 3/05 PM. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert A. Hall, M.D.
22b. ADDRESS: 3902 LAFAYETTE AVE. St. Louis 10, Mo.
22c. DATE SIGNED: 2/13/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 2/15/60
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Crematory
23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR: Drehmann-Harral, 1905 Union Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 15 1960
26. REGISTRAR'S SIGNATURE: Neal Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Warren Carver

Signature of Student Embalmer

Licensed Embalmer No. 3534

P. O. Address St Louis Mo

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.