

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

-60-008427

2 1527

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		Length of stay in 1b 13 yrs	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1105 N. 18th St. #108		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Peter Middle Last Johnson			4. DATE OF DEATH Month 2 Day 6 Year 60		
5. SEX Male	6. COLOR OR RACE Male Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1911	9. AGE (last birthday) 48 IF UNDER 1 YEAR IF UNDER 24 HR Months 7 Days 25 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Maker		10b. KIND OF BUSINESS OR INDUSTRY Mfg	11. BIRTHPLACE (City and state or country) Silver City Miss		12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME Walter Johnson		13b. MOTHER'S MAIDEN NAME Sarah Jefferson		14. NAME OF HUSBAND OR WIFE Mary Jane Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499-34-9143	17. INFORMANT Address Mary Jane Johnson 1105 N 18th St Apt 108		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subfascial Abscess of Lower Abdomen					INTERVAL BETWEEN ONSET AND DEATH 6 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Peritonitis and Septicemia				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.)			
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 2-5-60 - 3:55 AM to 2-6-60 and last saw ^{him} her live on 2-6-60		Death occurred at 8:10 ^{p.m.} on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. O. Richard MD</i> (Degree or title)		22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 2-9-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-12-60	23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis Co MO	
24. FUNERAL DIRECTOR JAS H. RANDLE & SON		ADDRESS 3133 Bell Ave		25. DATE RECD. BY LOCAL REG. FEB 9 1960	26. REGISTRAR'S SIGNATURE <i>Leah Smith M.D.</i> <i>mjb</i>

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

Student _____
Signature of Student Embalmer

Signed Esther N. Harris

Licensed Embalmer No. 445
P. O. Address 4181 2nd

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.