

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016976

FILED VS. APR 18 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3755** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Mo.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4245 MARYLAND</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4245 MARYLAND</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAHLON</b> Middle <b>JOHNSON</b> Last			4. DATE OF DEATH Month <b>3</b> - Day <b>29</b> - Year <b>60</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1-27-14</b>	9. AGE (last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LOOKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM JOHNSON</b>			13b. MOTHER'S MAIDEN NAME <b>LULU WILLIAMS</b>			14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>LUCILLE WILLIAMS 512 N. CHANNING</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Influenzal Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Influenza</b> DUE TO (c) <b>480x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-29-60</b> <b>3-18-60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 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 <b>MAR. 19, '60</b> to <b>MAR. 29, '60</b> and last saw <sup>her</sup> him alive on <b>MAR. 29, '60</b> Death occurred at <b>9:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Walter G. Young, M.D.</b> (Degree or title)				22b. ADDRESS <b>4635 Easton Ave.</b>		22c. DATE SIGNED <b>4-1-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>4-5-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PARK CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, Mo.</b>		
24. FUNERAL DIRECTOR <b>Luke Jones 1343 N. Garrison Ave.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>APR 4 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*L.P.*

**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

*Arthur L. Heilliard*

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.