

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-025323**

FILED VS JUN 20 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1711

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Florissant</b>		Length of stay in 1b <b>12 years</b>	c. CITY OR TOWN <b>Florissant</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1540 Arlington Drive</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1540 Arlington Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>ELMER</b> Last <b>JOHNSTON</b>			4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-78</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grain &amp; Dairy</b>	11. BIRTHPLACE (City and state or country) <b>Kirksmanville, Ky.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Jacob Johnston</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Shutt</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Geneva Johnston - 1504 Arlington</b> Address
--	--	---

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) <b>Polyp of distal Stomach, obstructing pylorus</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pernicious Anemia</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) <b>Dehydration and Malnutrition</b>		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 <b>ST. LOUIS, MO.</b>	COUNTY <b>ST. LOUIS</b>	STATE <b>MO.</b>
--	--	---	----------------------------	---------------------

21. I attended the deceased from **8-3-55** to **5-24-60** and last saw him alive on **5-21-60**  
Death occurred at **8:15** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Wm. G. Jones, M.D.</b> (Degree or title)	22b. ADDRESS <b>8321 N. Broadway (15)</b> <b>St. Louis, Mo.</b>	22c. DATE SIGNED <b>5-21-60</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>Funeral</b>	23b. DATE <b>6/1/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	23d. LOCATION (City, town, or county) (State) <b>Central Twp., Illinois</b>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <b>Donnell Funeral Home, Greenville</b> ADDRESS <b>Ill.</b>	25. DATE RECD. BY LOCAL REG. <b>5-31-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. Ill. 72

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.