

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

FILED VS AUG 22 1960

-60-032405

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8083** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>Indiana</b> b. COUNTY <b>Daviess</b>	
Length of stay in 1b		c. CITY OR TOWN <b>Washington</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>Rural Route # 3</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>ELLES</b> Middle <b>H.</b> Last <b>JOHNSON</b>			Month <b>AUGUST</b> Day <b>15</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/11/1905</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carmen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Washington, Indiana.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Unknown) Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Esther Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. Nil.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>Mary Esther Johnson, Rural Route # 3</b>		

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>CEREBRAL VASCULAR ACCIDENT</b>		<b>72 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>	<b>4 YEARS</b>
	DUE TO (c) <b>331x</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.	
<b>STATUS POST-OP AORTIO-ILIAC BY-PASS PROSTHESIS</b>		<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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from **AUGUST 8, 1960**, to **AUGUST 15, 1960** and last saw her/him alive on **AUGUST 15, 1960**  
 Death occurred at **7:20 P.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>C. Vermillion, M.D.</i>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>8/16/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) <b>Washington, Indiana.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 16 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INDIVIDUAL LICENSE

**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 \_\_\_\_\_

Licensed Embalmer No. 410

P. O. Address \_\_\_\_\_

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.