

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032410

FILED VS. AUG 26 1960

318

Primary Registration District No. 1003

Registrar's No. 8213

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY Pemiscot			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.			Length of stay in 1b	c. CITY OR TOWN Peach Orchard		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Jesse S. Johnson				4. DATE OF DEATH Month Day Year August 19, 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/12/1896	9. AGE (last birthday) 63	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) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Bardwell, Kentucky	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas J. Johnson			13b. MOTHER'S MAIDEN NAME Maggie Loasman			14. NAME OF HUSBAND OR WIFE Carrie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Carrie Johnson Peach Orchard, Missouri. 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) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arterio Sclerosis (Thrombosis)</u> DUE TO (c) <u>Arterio Sclerosis, Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>years</u> <u>years</u>
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 <u>7/28/60</u> to <u>8/19/60</u> and last saw her alive on <u>8/19/60</u> Death occurred at <u>10:35 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Arson Hendrix MD</u>				22b. ADDRESS <u>4268 Delor</u>		22c. DATE SIGNED <u>8/19/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-19-60	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Gideon, Mo.		23e. (State)	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 1700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. AUG 20 1960	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>		

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

*James Dumbley*

Licensed Embalmer No. 3653

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.