

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1960

-60-032411

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8658**

1. PLACE OF DEATH a. COUNTY None				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY None						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		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 BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4619 Ashland Ave.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LEO Middle F. Last JOHNSON				4. DATE OF DEATH Month SEPTEMBER Day 1 Year 1960						
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7/28/96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffeur (ret)			10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME John Johnson			13b. MOTHER'S MAIDEN NAME Fannie Barton			14. NAME OF HUSBAND OR WIFE Lovada 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.		17. INFORMANT Address Lovada Johnson, 4619 Ashland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE ASCITES							INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF ESOPHAGUS WITH METASTASES							SEVERAL MOS.			
DUE TO (c) 150 X										
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 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 MARCH 16, 1960 to SEPT. 1, 1960 and last saw her/him alive on SEPT. 1, 1960 Death occurred at 10:03 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.										
22. SIGNATURE <i>Thomas D. Bentley</i> (Degree or title) M. D.				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 9/2/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/6/60	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery			23d. LOCATION (City, town, or county) (State) Wellston, Mo.				
24. FUNERAL DIRECTOR Cunningham & Moore, 2405 Marcus ADDRESS				25. DATE RECD. BY LOCAL REG. SEP 4 1960		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

121120H 030000

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

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.