

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039333

FILED VS NOV 4 1960

290

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 143

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <b>Missouri</b> b. COUNTY <b>Phelps</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ft. Leonard Wood</b>		Length of stay in 1b <b>2 1/2 Months</b>	c. CITY OR TOWN <b>Rolla</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>US Army Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1203 W. 8th St.</b>		
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Franklin</b> Last <b>Johnson</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</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>21 Feb 1894</b>	9. AGE (last birthday) <b>66</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>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (City and state or country) <b>Vienna, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Deceased</b>			13b. MOTHER'S MAIDEN NAME <b>Deceased</b>		14. NAME OF HUSBAND OR WIFE <b>Edith Bryce Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1917-1919 1925-1943</b>			16. SOCIAL SECURITY NO. <b>497-32-9603</b>	17. INFORMANT <b>Edith B. Johnson, Rolla, Missouri</b> Address <b>1203 W. 8th St.</b>		
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>Aspiration, pneumonia</b> DUE TO (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Atherosclerosis and iliac artery embolism</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b> <b>several</b> <b>years</b> <b>recent</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic renal disease. Duodenal ulcer. Myocardial infarction</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 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 <b>27 July 1960</b> to <b>19 October 60</b> and last saw <sup>her</sup> him alive on <b>19 October 1960</b> Death occurred at <b>9:00 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Charles J. Koucky M.D.</b>			22b. ADDRESS <b>Ft. Leonard Wood, Mo.</b>		22c. DATE SIGNED <b>20 Oct 60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/20/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Steelville Cemetary</b>		23d. LOCATION (City, town, or county) (State) <b>Steelville, Mo.</b>		
24. FUNERAL DIRECTOR <b>Carl J. Glenn West 10th st., Rolla, Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-20-60</b>	26. REGISTRAR'S SIGNATURE <b>Eula Mae Anderson</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 4 1960

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**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

*Paul J. Glenn*

Licensed Embalmer No. 470

P. O. Address Rella, W.

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.