

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 ST. LOUIS, MISSOURI		Length of stay in 1b 19 DAYS	c. CITY OR TOWN TROY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.R. 3 EDWARDSVILLE, ILLINOIS

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
EDWARD	H.	JOHNSON	OCTOBER	8	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 MAR 24 1910	9. AGE (last birthday) 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN HELPER		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILLS	11. BIRTHPLACE (City and state or country) STEWART CO. TENN.	12. CITIZEN OF WHAT COUNTRY U. S. A.	

13a. FATHER'S NAME GEORGE W.W. JOHNSON	13b. MOTHER'S MAIDEN NAME ELIZABETH PULLEY	14. NAME OF HUSBAND OR WIFE BERTHA 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. 355-07-2944	17. INFORMANT Bertha Johnson EDWARDSVILLE IL

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) UREMIA		3-4 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) MALIGNANT HYPERTENSION	2 YEARS
	DUE TO (c) 445x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BRONCHOPNEUMONIA	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
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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 **SEPT. 19, 1960** to **OCT. 8, 1960** and last saw her/him alive on **OCT. 8, 1960**
 Death occurred at **5:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. P. Williams, M.D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/9/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE OCT. 12 1960	23c. NAME OF CEMETERY OR CREMATORY FRIEDENS	23d. LOCATION (City, town, or county) (State) TROY, ILLINOIS
24. FUNERAL DIRECTOR Jewel S. Edwards	ADDRESS TROY, ILLINOIS	25. DATE RECD. BY LOCAL REG. OCT 10 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 Jewel S. Edwards

Licensed Embalmer No. 3548

P. O. Address TROY, ILL.

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.