

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. NOV 3 1960

-60-039873
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10315

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis.</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Infirmary</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4714 Cupples</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Malcom</u> Middle <u>Johnson</u> Last				4. DATE OF DEATH Month <u>10</u> - Day <u>23</u> Year <u>'60</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-13-1911</u>	9. AGE (last birthday) <u>49</u>	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) <u>Porter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Pullman</u>		11. BIRTHPLACE (City and state or country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Robert Johnson</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>MARY Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>408-16-7783</u>		17. INFORMANT Address <u>MARY Johnson - 4714 Cupples</u>			
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>Massive Atelectasis of the Left Lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchiogenic Carcinoma of the Left Lung</u> DUE TO (c) <u>162:l.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>5:30</u> a.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>June 11, 1960</u> to <u>Oct. 23, 1960</u> and last saw ^{her} _{him} alive on <u>Oct 23, 1960</u> Death occurred at <u>5:30 a.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Bernard C. Randolph, M.D.</u>				22b. ADDRESS <u>4903 S Easton Ave.</u>		22c. DATE SIGNED <u>Oct 24, 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-28-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>J. McClellan 4535 Washington</u>			25. DATE RECD. BY LOCAL REG. <u>OCT 25 1960</u>		26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

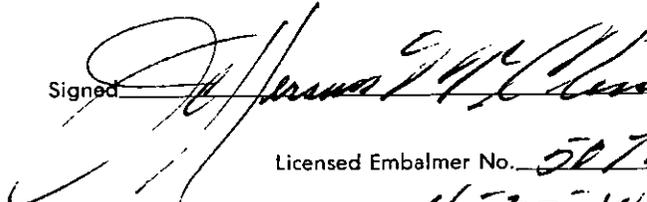
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 5070

P. O. Address 4535 WA

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.