ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4761 STATE FILE NUMBER 61-019123

FILED JUN 2 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI — Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Union

c. CITY OR TOWN: Anna — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 415 N. Green — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EFFIE, Middle ANN, Last JOHNSON

4. DATE OF DEATH: Month MAY, Day 17, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 12/23/1883

9. AGE (last birthday): 77 — 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): Cashier

10b. KIND OF BUSINESS OR INDUSTRY: Life Ins.,Co.

11. BIRTHPLACE (City and state or country): Anna, Illinois.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Benjamin Joseph Johnson

13b. MOTHER'S MAIDEN NAME: Emma M. Johnson

14. NAME OF HUSBAND OR WIFE: Nil.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) Nil.

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Elsie Hines, Address: Anna, Illinois.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): DIABETIC ACIDOSIS — INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): DIABETES MELLITUS — 9 YEARS

DUE TO (c): 260x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): GASTROINTESTINAL HEMORRHAGE, SITE UNKNOWN

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 FEB. 15, 1960, to MAY 17, 1961 and last saw her/him alive on MAY 17, 1961

Death occurred at 8:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. Vermillion, M. D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 5/18/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 5-20-61

23c. NAME OF CEMETERY OR CREMATORY: Anna Cemetery

23d. LOCATION (City, town, or county) (State): Anna, Illinois.

24. FUNERAL DIRECTOR — ADDRESS: Albert H. Hoppe Inc., 4700 Washington, Blvd.

25. DATE RECD. BY LOCAL REG.: MAY 19 1961

26. REGISTRAR'S SIGNATURE: Karl Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley H. Sifon

Licensed Embalmer No. 4193

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.