SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5174 -61-022761 STATE FILE NUMBER

AMENDED

FILED JUN 1 6 1961

1. PLACE OF DEATH
a. COUNTY

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

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1315 N. 7th Street | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 1315 N. 7th Street | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Mary Middle: M. Last: Johnson

4. DATE OF DEATH Month: 5 Day: 31 Year: 61

5. SEX Female

6. COLOR OR RACE Col.

7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 7-30-55

9. AGE (last birthday) 5 | 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) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Detroit, Mich.

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Peter Johnson, Jr.

13b. MOTHER'S MAIDEN NAME Vieaner Borden

14. NAME OF HUSBAND OR WIFE None

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

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs. Peter Johnson-1315 N. 7th St.

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) Sickle-cell Anemia.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 292.6
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ 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 decessed from _____, to _____ and last saw her/him alive on _____
Death occurred at 10:3 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul J. Simon (Degree or title) Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 6/2/61

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

23b. DATE 6-5-61

23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery

23d. LOCATION (City, town, or county) (State) St Louis Co. Mo.

24. FUNERAL DIRECTOR A.L. Beal Und. Co. ADDRESS -4303 Delmar

25. DATE RECD. BY LOCAL REG. JUN 2 1961

26. REGISTRAR'S SIGNATURE Hoad Smith, M.D.

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

Reg 4173

Mr Michek

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Caston Ave

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.