

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-022762

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5223

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

FILED JUN 18 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. St. Louis, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5140 Maffitt Ave</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>E.</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1961</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>8-6-1899</u>	9. AGE (last birthday) <u>61</u>	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) <u>Waiter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri Pacific R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Shreveport, La</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>Thornton Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Janie Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>Helen 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>none</u>	17. INFORMANT Address <u>Helen Johnson 5140 Maffitt Ave</u>
---	--	--

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) <u>Coronary occlusion;</u>		
DUE TO (b) <u>Atherosclerosis.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>420.1</u>	

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

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 _____ 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ 945 A m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>Joseph M. [Signature]</u>	(Degree or title) <u>Deputy [Signature]</u>	21b. ADDRESS <u>1300 Claef</u>	21c. DATE SIGNED <u>6-5-61</u>
--	--	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/9/61</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <u>Shreveport, La</u>	(State)
---	----------------------------	------------------------------------	--	---------

24. FUNERAL DIRECTOR <u>C.W. Roberts Und. Co</u>	ADDRESS <u>1416 N. Taylor Ave</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 5. 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith. M.D.</u>
---	--------------------------------------	--	--

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 James A Carter

Licensed Embalmer No. 4681

P. O. Address J. J. Moore

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.