SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-022764
STATE FILE NUMBER

AMENDED

FILED JUN 26 1961

Registrar District No. 318 Primary Registration District No. 1003 Registrar's No. 5586

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

AFFIDAVIT OF

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. CityHospital
Inside Limits Yes ☐ No ☐

d. STREET ADDRESS 7209 Minnesota ave. (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First William Middle Clifford Last Johnston

4. DATE OF DEATH Month June Day 13 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4-22-1916

9. AGE (last birthday) 45

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) Painter

10b. KIND OF BUSINESS OR INDUSTRY Painter Work

11. BIRTHPLACE (City and state or country) St.Louis,Missouri

12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME Arthur Johnston

13b. MOTHER'S MAIDEN NAME Louise Mauer

14. NAME OF HUSBAND OR WIFE Berniece

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.

17. INFORMANT Berniece Johnston Address 7209 Minnesota ave.

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) Cardiac Hypertrophy;

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

DUE TO (b) Cirrhosis of liver.

581-0

DUE TO (c)

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 deceased from _____ to _____ and last saw her/him alive on _____.
Death occurred at 2:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph M. Quinn Deputy Coroner (Degree or title)

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 6-14-61

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

23b. DATE 6-16-1961

23c. NAME OF CEMETERY OR CREMATORY Mt.Hope Cemetery

23d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Lemay,Mo.

24. FUNERAL DIRECTOR C.Hoffmeister Mortuaries ADDRESS 7814 S.Broadway

25. DATE RECD. BY LOCAL REG. JUN 15 1961

26. REGISTRAR'S SIGNATURE Hoard 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 Lewis C. Hoffman

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broa

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.