

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-034513

AMENDED

Registration District No. **1818**

Primary Registration District No. **1003**

Registrar's No. **8288**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4745a St. Louis</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Turner Johnson</b>				4. DATE OF DEATH Month Day Year <b>9 4 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil.</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (last birthday) <b>83</b>		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <b>5 18</b>	
11. BIRTHPLACE (City and state or country) <b>Grandchain, Ill.</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>THOMAS JOHNSON</b>				13b. MOTHER'S MAIDEN NAME <b>CAROLINE FREEMAN</b>		14. NAME OF HUSBAND OR WIFE <b>LAURA JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>ERA COLLINS</b> Address <b>4745 ST LOUIS AV</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<b>4200</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Auricular Fibrillation and Congestive Failure</b>						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 <b>8-28-61</b> to <b>9-4-61</b> and last saw him <b>KX</b> alive on <b>9-4-61</b>				Death occurred at <b>7:20</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. H. Hitley, M.D.</b>				22b. ADDRESS <b>2601 N. Whittier Street</b>		22c. DATE SIGNED <b>9-5-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>9-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON PK.</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS CO., MO.</b>	
24. FUNERAL DIRECTOR <b>WALTON 2707 Stoddard</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 6 1981</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 123 N Taylor

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.