

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **3045-61-039549**

AMENDED

Registration District No. **317** Primary Registration District No. **54** Registrar's No. **3045**

FILED NOV 15 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b DOA	c. CITY OR TOWN Clayton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7536 Parkdale Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle Anne Last Chesley Johnson			4. DATE OF DEATH Month October Day 29 Year 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/30/1934	9. AGE (last birthday) 27	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reservation Clerk	10b. KIND OF BUSINESS OR INDUSTRY Delta Air Lines	11. BIRTHPLACE (City and state or country) Heron Lake, Minn.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME John Brown	13b. MOTHER'S MAIDEN NAME Josephine Mrozek	14. NAME OF HUSBAND OR WIFE William Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address Josephine Chesley, Minneapolis, Minn.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbital Poisoning		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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 checked="" type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Intentional ingestion of overdose of medication
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20c. TIME OF INJURY Hour 10:20 a.m. XX Month, Day, Year 10/29/61 subject found	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bedroom of home (apt)	20f. CITY, TOWN, OR LOCATION COUNTY STATE Clayton St. Louis Missouri
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bedroom of home (apt)	20f. CITY, TOWN, OR LOCATION COUNTY STATE Clayton St. Louis Missouri
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Raymond Hand</i> Coroner Clayton, Mo.	22b. ADDRESS	22c. DATE SIGNED 11-4-61
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23a. BURIAL, CREMATION, ETC. DATE Removal 10-30-61	23c. NAME OF CEMETERY OR CREMATORY Ft. Schnelling Cemetery	23d. LOCATION (City, town, or county) (State) Ft. Schnelling, Minn.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. 10-30-61	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Harry E. Monroe

Licensed Embalmer No. 4495

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.