

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021380

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1269

STATE FILE NUMBER

**FILED MAY 23 1962**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay</b>		Length of stay in 1b <b>2 Yrs.-2 Mon.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mt. St. Rose Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5612 Goethe Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>JOHANS</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>22</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-1897</b>	9. AGE (last birthday) <b>64</b> IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President-Wohl Shoe Co. (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Effingham, Ill.</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John P. Johans</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Oswald</b>		14. NAME OF HUSBAND OR WIFE <b>Veronica E. Johans</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			17. INFORMANT Address <b>Veronica E. Johans 5612 Goethe Ave.</b>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ENCEPHALOMALACIA GENERALIZED</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Yrs</b>
DUE TO (b) <b>MULTIPLE CEREBRAL THROMBOSES</b>		
DUE TO (c) <b>...</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC PYELONEPHRITIS</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	
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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.)	
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from 7-3-61 to 4-22-62 and last saw her alive on 4-16-62  
Death occurred at 9:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. William Summister M.D.</i> (Degree title)	22b. ADDRESS <i>634 N. Grand</i>	22c. DATE SIGNED <i>4/24/62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 25, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshausner 4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>4-24-62</b>	26. REGISTRAR'S SIGNATURE <i>John M. ...</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 ITEM NO. SHOULD READ  
 1. GATE AMENDED  
 2. 202  
 3.  
 4. C  
 5. 1  
 6.  
 7. 1  
 8. 2  
 9. 9332X  
 10.  
 11.  
 12. 42-0  
 13.  
 42

USE BLACK INK OR TYPEWRITER RIBBON

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 James R. Deussen

Licensed Embalmer No. 4-527

P. O. Address \_\_\_\_\_

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.