

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-028811

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **7271**
FILED JUL 31 1962

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 ST. LOUIS, MISSOURI			Length of stay in 1b		c. CITY OR TOWN Clayton
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) #3 Brentmoor Park
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		5. SEX
First WILLIE Middle H. Last JOHNSTON			Month JULY Day 23 Year 1962		Female
6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-30-1869	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (last birthday) 92	
11. BIRTHPLACE (City and state or country) Withrow Spring, Ark.		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13a. FATHER'S NAME William Honey		13b. MOTHER'S MAIDEN NAME Ophelia Jane Polk		14. NAME OF HUSBAND OR WIFE Houston W. Johnston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Gale F. Johnston #3 Brentmoor Park	
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 1 MONTH
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					491X
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 checked="" 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		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.)	
Hour		Month, Day, Year		20f. CITY, TOWN, OR LOCATION	
a.m.		p.m.		COUNTY	
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.)		STATE	
21. I attended the deceased from DECEMBER 27, 1936 to JULY 23, 1962 and last saw her/him alive on JULY 23, 1962					
Death occurred at 5:35 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 7/24/62
F. R. BRADLEY, M. D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-26-1962		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
24. FUNERAL DIRECTOR Lupton Chapel Inc.		ADDRESS 7233 Delmar		23d. LOCATION (City, town, or county) St. Louis Co., Mo.	
25. DATE RECD. BY LOCAL REG. JUL 24 1962			26. REGISTRAR'S SIGNATURE Roan 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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis Mo.

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.