

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

8826 - 62-036326
STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. _____

FILED SEP 24 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59
1
2 *225*
3
4 *2*
5 *0*
6
7 *0*
8 *1*
9
10
11
12 *92-3*
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY		c. CITY OR TOWN <i>ST LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>DOA HOMER PHILIPS</i>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>9247 15th</i>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>Johnson</i> Last <i>Johnson</i>						4. DATE OF DEATH Month <i>9</i> - Day <i>9</i> - Year <i>62</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>1-5-24</i>		9. AGE (last birthday) <i>38</i>		IF UNDER 1 YEAR IF UNDER 24 HR Months <i>8</i> Days <i>9</i> Hours <i>9</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>St Louis MO</i>		12. CITIZEN OF WHAT COUNTRY <i>USA.</i>			
13a. FATHER'S NAME <i>JAMES JOHNSON</i>				13b. MOTHER'S MAIDEN NAME <i>BEULAH</i>				14. NAME OF HUSBAND OR WIFE <i>NONE</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES WW2</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>FRANCIS W HORTON</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhagic pancreatitis with marked necrosis involving the retroperitoneal space of the ascending and descending colon, plus shock.</i>										INTERVAL BETWEEN ONSET AND DEATH	
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) <i>587.0</i>								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 checked="" type="checkbox"/> NO <input 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <i>12:00 midnight</i> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Jeff Barracks</i> (Degree or title) <i>Deputy</i>						22b. ADDRESS <i>1300 Chestnut</i>			22c. DATE SIGNED <i>9-10-62</i>		
22d. BURIAL, CREMATION, OR REMOVAL (Specify) <i>REMOVAL 19-16-62</i>			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL</i>			23d. LOCATION (City, town, or county) (State) <i>JEFF BARRACKS MO</i>		
24. FUNERAL DIRECTOR <i>RELIABLE 1389 UNION</i>				ADDRESS		25. DATE RECD. BY LOCAL REG. <i>SEP 12 1962</i>		26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

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 Clarence Craun

Licensed Embalmer No. 4755

P. O. Address 1389 Union

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.