

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 11 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2064** STATE FILE NUMBER **60-008742**

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>21. Yrs</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CITY HOSPITAL #1</b>		d. STREET ADDRESS (If outside, give location) <b>1608, BIDDEL STREET</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JOHNICE</b> Middle _____ Last <b>PRESTON</b>			4. DATE OF DEATH Month <b>2</b> / Day <b>18th</b> / Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COL.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/1938</b>	9. AGE (last birthday) <b>21</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTICTS</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>JOHNIE PRESTON</b>		13b. MOTHER'S MAIDEN NAME <b>CRECIE JONES</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>487-42-3713</b>		17. INFORMANT Address <b>Mrs. Gertrude Preston 1608, BIDDEL STREET</b>	
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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) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>49ix</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 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.)	
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 **1140 P.** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Paul J. Smith Deputy Coroner</b>		22b. ADDRESS <b>1300 Coroner</b>		22c. DATE SIGNED <b>2/20/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2-25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, COUNTY MISSOURI</b>		25. DATE RECD. BY LOCAL REG. <b>FEB 23 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John J. Preston 2812, THOMAS ST.</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m. j. b.*

*[Handwritten scribble]*

**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 *[Handwritten Signature]*

Licensed Embalmer No. 4446  
P. O. Address 2812 Flo

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.