

FILED JUN 28 1963  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**63-026027**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

X C 2612111 SL-31319

**6597**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

**FILED JUN 23 1963**

Primary Registration District No.

**1003**

Registrar's No.

VS 300  
 Rev. 4/59

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 2/20

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis, Missouri</b>		Length of stay in 1b <b>12 days</b>	c. CITY OR TOWN <b>Caseyville</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Vets Admin Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>65 Circle Drive</b>
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>M</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>63</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>1/13/78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL APP.</b>	9. AGE (last birthday) <b>85</b>
13a. FATHER'S NAME <b>George Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	11. BIRTHPLACE (City and state or country) <b>Wisconsin</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give post or dates of service) <b>Yes SPAW</b>		14. NAME OF HUSBAND OR WIFE <b>Lenora M Johnson</b>	
17. INFORMANT <b>Lenora M Johnson (wife) see 2 above</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
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>CEREBRAL HEMORRHAGE</b>			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>PNEUMONIA - SUSPECT KLIBSELLA</b>			
DUE TO (c) <b>331x</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</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
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 <b>6/11/63</b> to <b>6/22/63</b> and last saw him alive on <b>6/22/63</b> Death occurred at <b>2:25 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>David J. Murphy MD</b>		22b. ADDRESS <b>VAH, St Louis, Mo.</b>	22c. DATE SIGNED <b>6/23/63</b>
23a. BURIAL, CREMATION, or REMOVAL DATE <b>6-24-63</b>		23b. NAME OF CEMETERY OR CREMATORY <b>St John's Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Collinsville, ILL</b>
24. FUNERAL DIRECTOR <b>Schroepel</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 24 1963</b>	26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>

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 Frank Proff

Licensed Embalmer No. 4356

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.

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