

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030777

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2054 STATE FILE NUMBER

FILED JUL 22 1963

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> COUNTY <u>ST. LOUIS, CO.</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b. <u>9 DAYS</u>	c. CITY OR TOWN <u>KIRK WOOD</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>220 E. MADISON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>			4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1963</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 3 1907</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HR. Hours <u>23</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>CHARLES JOHNSON</u>		13b. MOTHER'S MAIDEN NAME <u>WALTER BUREGG</u>		14. NAME OF HUSBAND OR WIFE <u>Hester Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>78-978-5871</u>		17. INFORMANT <u>Walter Johnson 236 E. Madison Ave</u>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)		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 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 6-12-1963 to 6-24-1963 and last saw him alive on 6-24-1963
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. A. Hemphill MD</u> (Degree or title)		22b. ADDRESS <u>COUNTY HOSP., CLAYTON, MO</u>		22c. DATE SIGNED <u>6-24-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-28, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FR. DICK'S ON'S Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>
24. FUNERAL DIRECTOR <u>John W. Hemphill 4083. Fillmore</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-27-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy Jr.</u>	

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 14002
 24003
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 4 2
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 13
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 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 Jeffrey E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4618 St. Ferdinand

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.