

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 30138
 Registrar's No. 1449

Registration District No. 284 Primary Registration District No. 101

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 days
(Specify whether
 In this community 14 years
years, months or days)

8. (a) PRINT FULL NAME Henry Johnson 525
 8. (b) If veteran, name war SP 8. (c) Social Security No. _____

4. Sex male 5. Color or race colored 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec. 20 1899
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>7</u>	<u>25</u>	_____ hr. _____ min.

9. Birthplace Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

12. Name Albert Johnson

13. Birthplace Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Lucinda Green
(City, town, or county) (State or foreign country)

15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lucinda Green
 (b) Address Kenloch

17. (a) burial (b) Date thereof 8-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheaton Park Cem.

18. (a) Signature of funeral director Frank J. Jones
 (b) Address 3129 Locust St. St. Louis

19. (a) AUG 15 1939 (b) DR. M. D. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town S. Kinloch
(If outside city or town limits, write "RURAL")
 (d) Street No. Oakridge Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14
 year 1939 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from 7/28/39
 _____, 19____, to 8/14/39, 19____;
 that I last saw him alive on 8/14/39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Lucidic Heart Disease - Myocardial Insufficiency</u>	<u>7/21/39</u>
Due to _____	_____
Due to _____	_____

Other conditions Embolic to L. Radial Artery at Wrist
(Include pregnancy within 3 months of death)

Major findings _____
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature James David (M. D. or other)
 Address 26 Adams County Hosp. Date signed 8/19/39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.