

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

I X19811

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1944

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 29478
Registrar's No. 767

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1519 Elliot Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOSEPH JOHNSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race NEGRO 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 August 13 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. 5 min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name CHARLES FRANK JOHNSON
13. Birthplace WEST POINT MISSISSIPPI
(City, town, or county) (State or foreign country)
14. Maiden name JULIA GAY
15. Birthplace SUMNER MISSISSIPPI
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles F. Johnson

(b) Address 1519 Elliott Ave

17. (a) Autopsy Board Date thereof 9-6-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Autopsy Board

18. (a) Signature of funeral director J. Beck

(b) Address 3500 Rutledge St

19. (a) SEP 6 1944 (b) J. H. Hodges
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St. Louis
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1519 Elliot Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. 20 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1944 hour 10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from August 13, 1944, to _____, 19____;
that I last saw him alive on August 13th, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death ATELECTASIS Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations NONE

Of autopsy NONE

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 Carl J. Bryan, M.D. (M. D. or other) _____

Address 1325 S. Grand Blvd. Date signed 8-14-44

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 with the above constitutes grounds for revocation of license.)

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