

MAR 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

791  
1003

4359  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. .... **1052**  
(c) City **St. Louis, Missouri** Street No. **City Sanitarium** St.  
(e) Length of residence in city or town where death occurred **62** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **John D. Johnson**

(a) Residence, No. **4814 a Delmar Blvd.** St. **12**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male**  
4. COLOR OR RACE **White**  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Divorced** (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1-28-1877**

7. AGE YEARS **62** MONTHS **0** DAYS **3**  
If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Clerk**  
9. Industry or business in which work was done, as saw mill, bank, etc. **Clerk unk.**  
10. Date deceased last worked at this occupation (month and year) **About 1920**  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

FATHER  
13. NAME **Richard M. Johnson**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Illinois**

MOTHER  
15. MAIDEN NAME **Annie W. Blow**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Missouri**

17. INFORMANT **W.L. Moore, M.D.**  
(ADDRESS) **5400 Arsenal**

18. BURIAL, CREMATION, OR REMOVAL PLACE **BELLE FOUNTAINE** DATE **FEB 2**, 19**39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **C. R. Lupton Sons 7233 DELMAR BLVD**

20. FILED **J.P. Budick**  
Local Registrar.

FEB 1 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-31-39**, 19

22. I HEREBY CERTIFY, That I attended deceased from **7-1-38**, 19, to **1-31-39**, 19.

I last saw him alive on **1-31-39**, 19. Death is said

to have occurred on the date stated above, at **12:50 P.M.**

The principal cause of death and related causes of importance were as follows:

**Epilepsy with Psychosis**  
**7-1-38x**

Date of onset

Other contributory causes of importance:  
**Chronic Myocarditis 7-1-38x**

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....  
(Signed) **Walter L. Moore M.D.** M. D.  
(Address) **5400 Arsenal St.**

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.

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,

*Bradford A. Miles*, or by

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

Signed *Bradford A. Miles*

Licensed Embalmer No. *2901*

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.**