

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5154
Do not use this space.

RECORDED MAR 13 1939

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No..... **1847**
 (c) City..... St. Louis (d) Street No. Homer Phillips Hospital St. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 23 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 595 Julia Johnson
 (a) Residence, No. 3137a LaSalle St. 18 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Johnson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 1, 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>60</u>	<u>1</u>	<u>20</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN)..... unknown (STATE OR COUNTRY)

FATHER

13. NAME Robert Crump

14. BIRTHPLACE (CITY OR TOWN)..... unknown (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Ellen White

16. BIRTHPLACE (CITY OR TOWN)..... unknown (STATE OR COUNTRY)

17. INFORMANT Evelyn Hilliard (ADDRESS) 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Feb 27, 1939

19. FUNERAL DIRECTOR (NAME) F. A. GREEN (ADDRESS) 2935 Franklin

20. FILED FEB 27 1939 J. D. Bruleck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 21 19 39

22. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 19 39, to Feb. 21, 19 39
 I last saw h. or alive on Feb. 21, 19 39 Death is said to have occurred on the date stated above, at 11:10 m. p. m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage

Date of onset 2/18/39

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis? clinical Was there an autopsy? no

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 Alcoholism (Signed) Hubert Emerson, M. D.
 (Address) 601 N Whittier

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 *J. A. Green*

....., Registered Apprentice No.

working under my personal supervision.

Signed

J. A. Green

Licensed Embalmer No. *9963*

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.