

REC'D JUN 12 1939

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

17104
Do not use this space.

791
1008

4638

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No.
(c) City St. Louis (d) Street No. City Hospital No. 1 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 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Mary Johnson

(a) Residence, No. 5411 Louisiana Ave. (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 76

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Linn Missouri

FATHER 13. NAME Renard Johnson

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

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE 5/23/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. H. Gebken
2842 Meramac

20. FILED MAY 22 1939 J. P. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/21/39, 19

22. I HEREBY CERTIFY That I attended deceased from 3/3/39, 19 5/21/39, 19
I last saw her alive on 5/21/39, 19. Death is said to have occurred on the date stated above, at 5. a m.

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

cerebral arteriosclerosis
generalized arteriosclerosis
Date of onset

Other contributory causes of importance:

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 Admission M. D.
(Signed) Admission
(Address) City Hospital No. 1

N. E.—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.

Em blank signed CF

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.