

550 JUL 12 1939

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

20595
Do not use this space.
5439

791
1008

1. PLACE OF DEATH

(a) County..... | Registration District No.....
(b) Township..... | Primary Registration District No.....
(c) City St. Louis, Mo. (d) Street No. St. Louis Children's Hospital 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. 9 mos. 25 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1519 N. Spring St. 11
(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 (write the word) Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-23-38

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
9 mo 25

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

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

FATHER 13. NAME Fred Wm. Johnston

14. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Aurelia Irvin

16. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)

17. INFORMANT Fred W. Johnston (ADDRESS) 1519 North Spring Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE ST Peter & Paul DATE 6/21/39

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc. (ADDRESS) 4700 Washington Blvd.

20. FILED JUN 19 1939 J. B. Brubaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-17, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-17, 1939, to 6-17, 1939.
I last saw him alive on 6-17, 1939. Death is said to have occurred on the date stated above, at 10 p.m.
The principal cause of death and related causes of importance were as follows:

Pneumonia, broncho-, type not determined
Hydrocephalus
Date of onset 6-16

Other contributory causes of importance: Hydrocephalus

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? no
If so, specify Renard Schwartzman, M.D. (Signed) 4500 Olive (Address)

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,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed *W W Wilkinson*

Licensed Embalmer No. *3575*

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.