

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23661
Registrar's No. 5934

REC'D AUG 11 1939

Registration District No. 201 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Homer Phillips
(d) Length of stay: In hospital or institution Since 6/27/39
In this community WIFE

3. (a) PRINT FULL NAME: 525 Eddie Mae Johnson
3. (b) If veteran, name war NO 3. (c) Social Security No. NIL

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Aaron Johnson 6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased April 9 1908

8. AGE: Years 35 Months 31 Days 2 24 hr. _____ min.

9. Birthplace St. Louis Missouri

10. Usual occupation Housework

11. Industry or business _____
MOTHER FATHER { 12. Name James Cooper
13. Birthplace Texas
14. Maiden name Myrtle Hunt
15. Birthplace Texas

16. (a) Informant's own signature E. Johnson
(b) Address 4370 Garfield

17. (a) Burial (b) Date thereat 2/17/39
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. H. Green
(b) Address 3517 Laclade Ave

19. (a) JUL 5 1939 (b) J. F. Bruback
Date received local Registrar's signature

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 4370 Garfield
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 3 year 1939 hour 11 minute A M.
21. I hereby certify that I attended the deceased from June 27, 1939 to July 3, 1939 that I last saw her alive on July 3, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Duration abt 12 days
Due to _____
Due to _____
Other conditions _____
Major findings: _____
Of operations _____
Of autopsy _____

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? _____
(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 H. J. Lyman (M. D. or other)
Address 2601 N. Whittier Date signed 7-5-39

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 *A.M. Chen*

Licensed Embalmer No. 1173

P. O. Address. 3517 Soledad

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.