

WHILE I REMAIN—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

24173

State File No. _____

AUG 11 1939

Registrar's No. 6446

Registration District No. 291

Primary Registration District No. _____

1. PLACE OF DEATH: 1008

(a) County _____

(b) City or town St. Louis *2*

(c) Name of hospital or institution: 2739 Hickory St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ernest Johnstone 523

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 5. Color or race Negro

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Sept. 6 1904
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>10</u>	<u>12</u>	hr. _____ min. _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business _____

MOTHER FATHER { 12. Name Benj. F. Johnstone

13. Birthplace Texas

14. Maiden name Mary Alexander

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Eleanor Johnstone

(b) Address 2739 Hickory St.

17. (a) Burial (b) Date thereof July 22 '39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Russell Untd. Co.

(b) Address 2732 Pine Street

19. (a) JUL 22 1939 (b) J. B. Breda
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis *22*
(If outside city or town limits, write "RURAL")

(d) Street No. 2739 Hickory
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 18
year 1939 hour 7 minute 5:35 P.M.

21. I hereby certify that I attended the deceased from 6-19-39 to 7-18-39 1939
that I last saw him alive on 7-18-39 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 6 mo

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically

Major findings: T. A. Bacilli

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? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? Yes (Specify type of place) _____
(a) Means of injury _____

23. Signature J. Breda (M. D. or other) _____
Address 832 S. Jefferson Date signed 7/28/39

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.....

Joel Russell

Licensed Embalmer No.....

4112

P. O. Address *2732 Pine St. St. Louis*

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.