

WHILE PLAINLY—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

27816

State File No.

7316

Registration District No.

1003

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lutheran Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST LOUIS
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL") **[NR]**
(d) Street No. 30 Joy Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 48 Years years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22
year 1939 hour 2:50 P.M. minutes _____ M.
21. I hereby certify that I attended the deceased from 6/8/39
_____ 19____ to 8/22/39 19____;
that I last saw her alive on 8/22/39 19____;
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Johanna Johnson 525
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 1 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 9 22 hr. min.

9. Birthplace Sweden
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER
12. Name Johns Olson JOHNSON
13. Birthplace Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Petrenelle Olson
15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Cooper
(b) Address 2822 Lemp Ave

17. (a) Burial (b) Date thereof August 26 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Churchyard

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave

19. (a) AUG 24 1939 (b) [Signature]
(Date and time of final report) (Registrar's signature)

Immediate cause of death _____
Arterio-sclerosis
Chronic Myocarditis
Due to Chr. Interstitial Nephritis
Duration _____ years
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 3554 Victor St Date signed 8/22/39

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.....

Francis J. Owens

Licensed Embalmer No. *7745*

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.