

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **10192**

**1. PLACE OF DEATH:** *In Garage*

(a) County ST. LOUIS AT 709. *Stinker*

(b) City or town ST. LOUIS

(c) Name of hospital or institution: 801 CLARKSTON COURT PL.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO. (b) County ST. LOUIS

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 19

(d) Street No. 801 CLARKSTON COURT PL. (If rural, give location)

(e) If foreign born, how long in U. S. A.? No Physician in Attendance years.

**3. (a) PRINT FULL NAME** MILTON JOHNSON 525

**8. (b) If veteran,** name war NO. **3. (c) Social Security** No. 487-14-3896

**4. Sex** MALE **5. Color or race** COLO. **6. (a) Single, widowed, married, divorced** MARRIED

**6. (b) Name of husband or wife** THE DONIA JOHNSON **6. (c) Age of husband or wife** 52 years alive. 2 FEB. 1881 (Month) (Day) (Year)

**7. Birth date of deceased** (Month) (Day) (Year)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Nov day 26 year 1939 hour 1:41 minute P. M.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

**8. AGE:** Years 58 Months 9 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** ST. LOUIS MO (City, town, or county) (State or foreign country)

**10. Usual occupation** PORTER

**11. Industry or business** VARIOUS PLACES

**MOTHER FATHER**

**12. Name** AUGUSTUS JOHNSON 7

**13. Birthplace** UNKNOWN UNKNOWN (City, town, or county) (State or foreign country)

**14. Maiden name** UNKNOWN UNKNOWN (City, town, or county) (State or foreign country)

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

**Immediate cause of death** Chronic Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

**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

**16. (a) Informant's own signature** Willie Jones

**(b) Address** 3853 Wentworth Ave. Chicago, Ill.

**17. (a) BURIAL** (Burial, cremation, or removal) **(b) Date thereof** 11-30-39 (Month) (Day) (Year)

**(c) Place: burial or cremation** GREEN WOOD

**18. (a) Signature of funeral director** LOVE UND. CO. INC.

**(b) Address** 3103 WASHINGTON BLVD.

**19. (a) NOV 29 1939** (Date received local registrar) **(b)** [Signature] (Registrar's signature)

**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? 4

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)

**23. Signature** Alfred Perry (M. D. or other)

**Address** Deputy Coroner **Date signed** 11/29/39

WRITE 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.

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**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 Arthur R. Hilliard

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson St

**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.**