

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.

STANDARD CERTIFICATE OF DEATH

State File No. **41440**

Registrar's No. **10563**

Registration District No. **1000**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town St Louis
 (c) Name of hospital or institution: Homer Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9 days
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME John Johnson
 8. (b) If veteran, name war _____
 8. (c) Social Security No. 525 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
 7. Birth date of deceased August 25th. 1910
 (Month) (Day) (Year)

8. AGE: Years 229 Months 3 Days 12
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Unemployed

MOTHER FATHER { 12. Name Timothy Johnson

13. Birthplace Unavailable Arkansas
 (City, town, or county) (State or foreign country)

14. Maiden name Daisy Hickey

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

16. (a) Informant's own signature Daisy Johnson

(b) Address West End Hotel Apt. #503

17. (a) Burial (b) Date of interment 12-11-39
 (Burial, cremation, or removal) (Month)-(Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Wm. J. Hickey

(b) Address 4107 Finney Ave.

19. (a) DEC 11 1939 (b) _____
 (Date) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. West End Hotel, Room 503
937 (Address, if location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 7 day 7
 year 1939 hour 6:00 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 29, 1939, to December 7, 1939
 that I last saw him alive on December 7, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Lung Abscess, Non Tuberculous
cause unknown
 Duration 1 mo

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 114 lb.

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 H. J. Lyman (M. D. or other)

Address 2601 N. Whittier Date signed _____

12/6/39

STATEMENT BY LICENSED EMBALMER

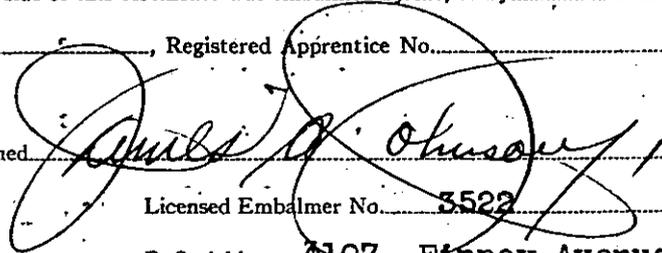
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue**

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.