

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
JAN 12 1946

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41754

State File No.

Registration District No. 501

Primary Registration District No.

Registrar's No. 10877

1. PLACE OF DEATH: 1003 /
(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: St. Marys Infer
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 1 day
years, months or days)

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

4. Sex Fem. 5. Color or race Col. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jefferson Johnson 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Sept 8 1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days 7 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business At Home

MOTHER { 12. Name Isaac Gower

13. Birthplace Nashville Tenn. (City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant's own signature Marcelle Johnson
(b) Address 301 Wash. St. Lovej. Ill.

17. (a) Burial (b) Date thereof 12/21/30
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Woodson
(b) Address 111 N. 13th St. E. Wash.

19. (a) DEC 20 1939 (b) J. F. Woodson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 2
(a) State Illinois (b) County St. Clair
(c) City or town Lovejoy (If outside city or town limits, write "RURAL")
(d) Street No. 301 Wash. St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15
year 1939 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from Dec 14
1939, to Dec 15 1939;
that I last saw him alive on Dec 15 1939;
and that death occurred on the day and hour stated above.

Immediate cause of death Acute
Chronic Nephritis
Due to Hypertension
Due to Hemiplegia
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration
Several
weeks

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 E. F. Woodson (M. D. or other) M.D.
Address 1005 N. 2nd St. Date signed 12/16/39
E. F. Woodson

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2532

P. O. Address 117 N. 13th St. E. Ed.

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.