

MAY 15 1940 791

Primary Registration District No. 1003

Registrar's No. 3030

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: Homer G 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 years, months or days)
 In this community Unknown abt. 23 yrs.

3. (a) PRINT FULL NAME WALTER JOHNSON 525

3. (b) If veteran, name war Nil 3. (c) Social Security No. 492-01-7034

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ara Johnson 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June 20, 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>9</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Trucker

11. Industry or business International Shoe Company

12. Name Unknown

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

14. Maiden name Millie (Unk)

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

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

(b) Address 1329 Webster

17. (a) Burial (b) Date thereof 8/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director J. M. Green

(b) Address 3517 Paikade Ave

19. (a) APR 1 1940 (b) [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 21
(If outside city or town limits, write "RURAL")
 (d) Street No. 1329 a Webster
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
 year 1940 hour 4:35 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 21, 1940, to March 29, 1940;
 that I last saw him alive on March 29, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease

Duration

6 yrs.

Due to _____

Due to _____

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings: [Signature]
 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 Whittier Date signed _____

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.

14 10⁰⁰ Henry
wife & children
on record

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



Licensed Embalmer No. 1173

P. O. Address 3517 Soledad Ave

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.