

No. 2
1939
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAY 15 1940 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13687

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 3889

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
715 Mound St
(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

3. (a) PRINT FULL NAME Betty Johnson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male race W

5. Color of hair Blk

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3/31/40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. _____ min.

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation W

11. Industry or business _____

MOTHER FATHER { 12. Name Carl Johnson

13. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

14. Maiden name Leta Reed

15. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Alice York

(b) Address 1429 N. 10th St

17. (a) _____ (b) Date thereof 3/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutledge

19. (a) APR 30 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

(c) City or town St Louis 26
(If outside city or town limits, write "RURAL")

(d) Street No. 715 Mound St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31
year 1940 hour 945 minute 17 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth Duration _____

Due to _____

Due to Premature Birth

Other conditions (Include pregnancy within _____ 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)

(a) Means of injury 5

23. Signature Joseph M. Richter (M. D. or D.O.)
Address Dep. Car Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT 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. _____

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.