

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **16890**
Registrar's No. **4368**

Registration District No. **791**

Primary Registration District No. _____

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 27 hrs 55 min
In this community Unknown (Specify whether years, months or days)

3. (a) PRINT FULL NAME LONNIE JOHNSON 525
3. (b) If veteran, name war NO NE 3. (c) Social Security No. NO NE

4. Sex MALE 5. Color or race COL 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 7 5 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 10 7 hr. min.

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

10. Usual occupation WATCHMAN 9

11. Industry or business _____
12. Name George Johnson
13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)
14. Maiden name JULIA BATISTA
15. Birthplace CHESTER ILL
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Blakeman
(b) Address 4150 ENRIGHT.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-17-1940
(Month) (Day) (Year)
(c) Place: burial or cremation SPARTA, ILL

18. (a) Signature of funeral director Bernice Roney
(b) Address 3103 Washington Blvd
19. (a) MAY 16 1940 (b) _____
(Date of local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 3926 Page
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12
year 1940 hour 12:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from 5-11, 1940, to 5-12-40, 19____;
that I last saw him alive on 5-12-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Unknown

Due to Complicating: Uremia, Kyphoscoliosis Thoracic Spine
Right Flaccid Paralysis

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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 M. E. S. Allen (M. D. or other) _____
Address 2601 N 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.

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 *Robert A. Powell*

Licensed Embalmer No. *3402*

P. O. Address *3100 Franklin*

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.