

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33913**
Registrar's No. **8610**

Registration District No. **791**

Primary Registration District No. **1003**

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 **3921 Hereford St**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3921 Hereford**
(Specify whether)
In this community **20 years**
years, months or days

3. (a) PRINT FULL NAME **Robert E. Johnson**

3. (b) If veteran, name war **-----** 3. (c) Social Security No. **493-09-1488**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Margaret Johnson** 6. (c) Age of husband or wife if alive **39** years
7. Birth date of deceased **Oct. 1, 1889**
(Month) (Day) (Year)

8. AGE: Years **51** Months **0** Days **15** If less than one day hr. _____ min. _____

9. Birthplace **Greenville Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business **Prior Inspr. Century Electric**

12. Name **John H. Johnson**
13. Birthplace **Greenville Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Margaret Johnson**
(b) Address **3921 Hereford**

17. (a) **Burial** (b) Date thereof **10/19/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hiram Cemetery**

18. (a) Signature of funeral director **Walter Halden**
(b) Address **2331 S. Broadway**

19. (a) **OCT 18 1940** (b) **J. R. B. [Signature]**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE, OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **14 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **3921 Hereford**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **16**
year **1940** hour **6** minute **P. M.**

21. I hereby certify that I attended the deceased from **September 1938**
_____, 19____, to **October 16, 1940**
that I last saw him alive on **Oct. 16, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis** Duration **4 yrs**

Due to **1/30**
Due to _____

Other conditions **Repeated Cardiac Decompensation**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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 **J. R. B. [Signature]** (M. D. or other)
Address **1150 Olive** Date signed **Oct 18 - 40**

Dr. H. T. Brown

47238

Dr. H. T. Brown

4500 Olive

7.3800
Donner 1909

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 *Frank J. Williams*

Licensed Embalmer No. *26725*

P. O. Address *Brownsville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.