

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34194

State File No. _____

8891

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. _____

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 3 days (Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME Sam Johnson

3. (b) If veteran, name war _____ 3. (c) Social Security No. 472-12-1596

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

6. (b) Name of husband or wife Mary Johnson 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Jan 12 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 9 Days 13 If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) Ky 1

10. Usual occupation Labor 9

11. Industry or business _____

12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant Mary Johnson

(b) Address 306 S Ewing

17. (a) Burial (b) Date thereof Oct 29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director F. A. Green

(b) Address 2915 Franklin ave

19. (a) OCT 29 1940 (Date received at registrar) (b) J. Fredrick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St Louis 22
(If outside city or town limits, write "RURAL")

(d) Street No. 306 S Ewing
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25
year 1940 hour 5:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from October 23, 1940, to October 25, 1940,
that I last saw him alive on October 25, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilitic Cerebral Thrombosis Duration Indef.

Due to _____

Due to _____

Other conditions 34
(Include pregnancy within 3 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) (e) Means of injury _____

23. Signature W. E. Erwin (M. D. or other) _____

Address 2600 Whittier Date signed _____

10/28/40

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

J. A. Gorman

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

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.