

No. 2  
13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
7911 1003

State File No. **36237**  
Registrar's No. **9010**

Registration District No. \_\_\_\_\_

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: Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 days  
(Specify whether  
In this community 17 years  
years, months or days)

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL") 19  
(d) Street No. 4384 Enright Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30  
year 1940 hour 12:40 minute \_\_\_\_\_ AM.

21. I hereby certify that I attended the deceased from  
October 18, 1940, to October 30, 1940;  
that I last saw him alive on October 30, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage Duration 12 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy As above

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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. E. Erwin (M. D. or other) \_\_\_\_\_  
Address 2600 Chatter St Date signed 10/31/40

3. (a) PRINT FULL NAME Mack Johnson

3. (b) If veteran, name war None (c) Social Security No. 492-10-5245

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

6. (b) Name of husband or wife Azalie 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased October 6, 1901  
(Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 24 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Turrell Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business Merchants Ice & Fuel Co.

12. Name Mack Johnson

13. Birthplace Unavailable 9  
(City, town, or county) (State or foreign country)

14. Maiden name Missouri White

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

16. (a) Informant Azalie Johnson

(b) Address 4384 Enright Avenue

17. (a) Burial (b) Date thereof 11/4/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Sells

(b) Address 4107 Finney Avenue

19. (a) NOV 1 1940 (b) \_\_\_\_\_  
(Date received local registrar)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

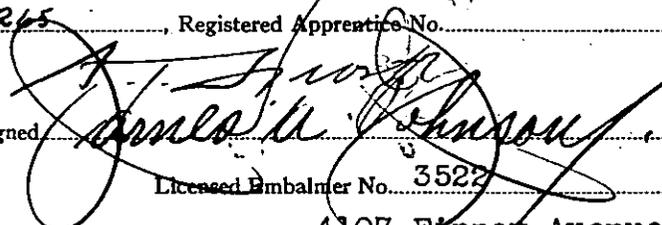
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

**James A. Johnson & A.J. Frost # 265**

Registered Apprentice No. ....

working under my personal supervision.

Signed



Licensed Embalmer No. **3522**

P. O. Address **4107 Finney Avenue**

**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.**