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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 6 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22862  
State File No. 6436  
Registrar's No.

Registration District No. 7911

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State. Missouri (b) County.....  
(c) City or town. St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1009 N. 14th Street  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Robert Johnson Jr.  
3. (b) If veteran, name war..... 3. (c) Social Security No.....  
4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced. B  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased 6 12 42  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 13  
year 42 hour 11 minute 40 a.m.  
21. I hereby certify that I attended the deceased from 6:00 P.M.  
6 - 12 1942 to 11:40 A.M 6-13-42  
that I last saw him alive on 6 - 13 1942  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
7 hr. 40 min.  
9. Birthplace. St. Louis Missouri  
(City, town, or county) (State or foreign country)

Immediate cause of death  
Hemorrhage Neonatorum  
Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....

MOTHER FATHER  
11. Industry or business.....  
12. Name. Robert Johnson  
13. Birthplace. Unknown Mississippi  
(City, town, or county) (State or foreign country)  
14. Maiden name. Ernestine Wilson  
15. Birthplace. Unknown Mississippi  
(City, town, or county) (State or foreign country)  
16. (a) Informant Katherine May Sherard, R.N.  
(b) Address 2601 N. Whittier Street  
17. (a) Burial (b) Date thereof JUL 31 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CITY CEMETERY  
18. (a) Signature of funeral director J. Hamilton  
(b) Address City Health Dept  
19. (a) JUL 26 1942 (b) J. F. Bredeck  
(Date recorded by local Registrar) (Registrar's signature)

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) Means of injury.....  
23. Signature J. F. Bredeck (D. or other).....  
Address 2601 N. Whittier State Missouri Date signed 7-27-42

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

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**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 the above constitutes grounds for revocation of license.)**

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22862  
Registrar's No. 6436

Registration District No. 991

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 or institution: H. G. Phillips Hosp  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Robert Johnson Jr  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June, 1942, year 1942, hour 9 minute 30 M.  
21. I hereby certify that I attended the deceased from 9 1942;  
that I last saw him alive on 9 1942;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....  
Duration.....

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive, years.....  
7. Birth date of deceased: June 12 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day, hr min.)  
54 11 10 15

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

10. Usual occupation.....

11. Industry of business.....

MOTHER FATHER  
12. Name.....  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof Jul-31-1942  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) SEP 5 1942 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

Due to.....  
Due to.....  
Other conditions.....  
(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..... (M. D. or other).....  
Address..... Date signed.....

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

SUPPLEMENTARY

S-22862