V. S. No. 2
100M—2-43
Rev. 5-17-43
I X3569

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23135

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 6583

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0 BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days (Specify whether
In this community 87 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ------ 000 17

(c) City or town Saint Louis 9/9
(If outside city or town limits, write "RURAL")

(d) Street No. 4540 Lindell Blvd.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ------- 0

3. (a) PRINT FULL NAME Ann Johnson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro 3

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife ? Johnson

6. (c) Age of husband or wife if alive ---- years

7. Birth date of deceased Unavailable 1856
(Month) (Day) (Year)

8. AGE: Abt. Years 87 Months Days If less than one day hr. min.

9. Birthplace Sappington, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Maid (Domestic)

11. Industry or business Private family

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

MOTHER
14. Maiden name Unavailable
15. Birthplace Unavailable 9
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph O'Neil
(b) Address 4540 Lindell Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/43
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) JHH (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1943 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from July 3, 1943, to July 19, 1943;
that I last saw her alive on July 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Sepsis - ant. abdominal wall, hemolytic staph. aureus.

Due to fistulous tract from gastric lesion probably

Due to carcinoma

Other conditions pulmonary edema
(Include pregnancy within 3 months of death)

Major findings:
Of operations Ant. Abdominal abscess - anaerobic
Of autopsy tract from stomach to ant. abdominal lesion

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature M. C. Abney 0 (M. D. or other)

Address BARNES HOSPITAL Date signed 7/20/43

(Licensed Embalmer's Statement on Reverse Side)

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~~

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Av. St. Lou

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, fact should be so stated above.