

S. No. 2  
DM-2-43  
5-17-39  
1-15-45  
1-15-55

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26781**

**AUG 18 1945**  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7256**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Hours  
(Specify whether years, months or days)

In this community Since Birth

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 8548 Lowell Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DRUSCILLA H. JOHNSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11  
year 1945 hour 12 minute 10 P. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

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

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept. 9, 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years: Months Days If less than one day

67 11 2 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Pneumonia  
cause undetermined

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

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

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

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

Of autopsy \_\_\_\_\_

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name William H. Parkinson

13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Clarkin

15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant James Johnson

(b) Address 8548 Lowell Street

17. (a) Burial (b) Date thereof 8/14/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) AUG 12 1945 J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

23. Signature Thomas F. Callahan  
While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_

Address Deputy Coroner Date signed 8/12-45

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 Francis C. Williamson

Licensed Embalmer No. 3665

P.O. Address St Louis

**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.**