

U. S. No. 2
FORM-5-43
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State File No. 11201

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

FILED DEC 20 1943

Registration District No. 1818

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(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: 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 16 days
years, months or days)

3. (a) PRINT FULL NAME Lafayette James Johnson

3. (b) If veteran, name war no 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Suey 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased March 14 1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation retired farmer

11. Industry or business _____

12. Name Joseph Johnson

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

14. Maiden name Unknown

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

16. (a) Informant Carl Johnson

(b) Address 6212 Bell

17. (a) removal (b) Date thereof 12-15-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Corning Ark

18. (a) Signature of funeral director W. H. Irby
(b) Address Pector, Arkansas

19. (a) DEC 15 1943 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County 3 NR.
(c) City or town Corning
(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 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1943 hour 11:20 minute P M.

21. I hereby certify that I attended the deceased from Nov
29, 1943, to Dec 14, 1943;
that I last saw him alive on Dec 14, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration _____

Due to Arteriosclerotic Heart Disease

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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) (c) Means of injury _____

23. Signature Melvin L. Goldman (M. D. or other) _____

Address BARNES HOSPITAL Date signed 12-16-43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Howard F. Rowland

Licensed Embalmer No. 3114

P. O. Address. Attonia Mo

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.