

FILED MAR 1 1944

State File No. _____

Registration District No. **378**

Primary Registration District No. **1003**

Registrar's No. **1593**

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: **CITY 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 **Mo** (b) County _____
(c) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1146 NEUCHÂTEAU AVE**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ORRA JOHNSTON**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased: **JAN 11 1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **1** Days **5** If less than one day _____ hr. _____ min.

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

10. Usual occupation **W.P.A. (RETIRED)**

11. Industry or business _____

MOTHER FATHER

12. Name **CLEM JOHNSTON**

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

14. Maiden name **W. K. WYN**

15. Birthplace **W. K. WYN** (City, town, or county) (State or foreign country)

16. (a) Informant **Thomas Collins**

(b) Address **3745 W. Pine Bl.**

17. (a) **BURIAL** (b) Date thereof **FEB. 16 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **PARKLAWA CEM**

18. (a) Signature of funeral director **L. Mullen**

(b) Address **5165 Delmar Bl.**

19. (a) **FEB 18 1944** (b) **J. J. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16** year **1944** hour **1** minute **30** A.M.

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: **Coronary Sclerosis Arterio Sclerosis**

Due to _____

Due to **9H**

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (9) Means of injury **3**

23. Signature **Arthur J. Perry** (M. D. or other) _____
Address _____ Date signed **2/18/44**

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.....

B. G. Farris

Licensed Embalmer No. *3384*

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.