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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

Primary Registration District No.

State File No. 4405

Registrar's No. 990

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Missouri
(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 42 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Wayne

(c) City or town Fairfield
(If outside city or town limits, write "RURAL")

(d) Street No. 405 E. Delaware
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Herman Johnson

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased About 1889 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 56			hr. min.

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

10. Usual occupation Painter

11. Industry or business

MOTHER FATHER

12. Name Robert B. Neal

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Duane Johnson

(b) Address Fairfield, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-31-45 (Month) (Day) (Year)

(c) Place: burial or cremation Fairfield, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JAN 31 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30 year 1945 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from December 19 1945 to January 30 1945 that I last saw him alive on January 30 (4:10 am) 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Hemorrhage — 3 hours

Due to Esophageal varices

Due to Cirrhosis

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature F R Bradley (M. D. or other)

Address Barnes Hospital, Date signed 1/31/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....1867.....

P. O. Address.....

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.