. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1945

Registration District No. 818

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 7868

Registrar's No. 2961

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: St. Louis Children's 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 Missouri (b) County Montgomery
(c) City or town New Florence
(If outside city or town limits, write "RURAL")
(d) Street No. NR.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Janice Kaye Johnson

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

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 September (Month) 14 (Day) 1944 (Year)

8. AGE: Years	Months	Days	If less than one day
	6	17	hr. min.

9. Birthplace New Florence (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Deward Johnson
13. Birthplace Montgomery County (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Dorothy Gilman
15. Birthplace Montgomery County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Deward Johnson
(b) Address New Florence, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation New Florence, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) APR 2 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st year 1945 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from 3-17, 1945, to 4-1, 1945, that I last saw her alive on 4-1, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis non-epidemic

Due to

Due to

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Gilbert B. Forbes (M. D. or other)
Address Children's Hosp. Date signed 4/1/45

(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 Albert E. Hoppe

Licensed Embalmer No. 2971

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.