

FILED APR 11 1945

Registration District No. 144

Primary Registration District No. 5564

Registrar's No. 2

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether \_\_\_\_\_)  
6 life

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Rural (If outside city or town limits, write "RURAL") \_\_\_\_\_

(d) Street No. near minimum (If rural, give location)

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

3. (a) PRINT FULL NAME Louisa Ann Johnson

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5  
year 1945 hour 3:30 minute P M.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife H. C. Johnson, deceased

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
4 1865

7. Birth date of deceased. \_\_\_\_\_  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
Feb 18 1945 to March 5 1945  
that I last saw him alive on March 3 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemiplegia Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
80 2 1 hr. \_\_\_\_\_ min.

Due to Senility & Demented

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

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

10. Usual occupation Housewife

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

MOTHER FATHER

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

12. Name Alfred E. Green

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

14. Maiden name Melvinne Johnson

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

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

Of autopsy no

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Pursha Johnson

(b) Address 202 Ave. 21st St.

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

17. (a) Burial (b) Date thereof 3-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation minimum

(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? \_\_\_\_\_

18. (a) Signature of funeral director Norman White 650ms

(b) Address 1001st St.

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

19. (a) Mar 21, 1945 (b) Mrs. E. E. Howard  
(Date received local registrar) (Registrar's signature)

23. Signature C. J. Jones, M.D. (M. D. or other) \_\_\_\_\_  
Address 1001st St. Date signed 3-7-45

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

1365

RECEIVED

District Health Officer No. 4  
District File Number 445-456  
Date Filed 4-9-45

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.....

was not embalmed, Registered Apprentice No. ....  
working under my personal supervision.

Signed Arnel J. White

Licensed Embalmer No. 3012

P. O. Address Imitor, Md.

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.