

FILED APR 23 1945

318

Primary Registration District No.

1003

Registrar's No.

3075

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(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: St. Louis City Hospital #1. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ina K. Johnson

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 Unknown

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

7. Birth date of deceased. About 53 Years
(Month) (Day) (Year)

8. AGE alt - 53 Years Months Days If less than one day
hr. min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown

13. Birthplace Lebanon New Jersey
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Mrs. Mozell Kirksey & City Hosp

(b) Address Lebanon New Jersey

17. (a) Burial (b) Date thereof 4 6 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) APR 6 1945 (b) J. J. Baker
(Date received local registrar) (Registrar's signature)

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. 2409 N 32nd
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2nd
year 1945 hour 5:00 minute P. M.

21. I hereby certify that I attended the deceased from 3/22/45
to 4/2/45, 19____, to 4/2/45, 19____;
that I last saw her alive on 4/2/45, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to _____
Due to _____

Other conditions Morphine addiction
(include pregnancy within 3 months of death)
Major findings: withdrown symptoms
Of operations Complications of unknown etiology
Of autopsy Pulmonary tuberculosis and Bronchopneumonia

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)
(e) Means of injury _____
23. Signature Ellis J. Lepst (M. D. or other)
1515 Lafayette 4/4/45
Address _____ Date signed _____

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

06
17
9

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..... *Choin D. Mc Dermott*.....
Licensed Embalmer No..... *3024*.....
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.