

S. No. 2  
DM-8-43  
v. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15243

State File No. \_\_\_\_\_

FILED JUN 9 1945

Registration District No. \_\_\_\_\_

8

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

4696

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:  
Homer Phillip Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hours  
(Specify whether \_\_\_\_\_)

In this community 36 years  
(years, months or days)

3. (a) PRINT FULL NAME Emma Johnson

(b) If veteran, name war No

(c) Social Security No. None

4. Sex Female 5. Color or race Negro

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

(b) Name of husband or wife Felts Johnson

(c) Age of husband or wife if alive 69 years

7. Birth date of deceased May 27th 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>11</u>	<u>28</u>	hr. _____ min. _____

9. Birthplace Holly Springs Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Nil

12. Name Alfred Rook

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

14. Maiden name Hester Cuttler

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

16. (a) Informant Felts Johnson

(b) Address 4340 Labadie Apt. 7

17. (a) Burial (b) Date thereof 6-1-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Ave.

19. (a) MAY 28 1945 J. F. [Signature]  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600

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

(d) Street No. 4340 Labadie Apt. 7  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25th  
year 1945 hour 2 minute 30 P.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 \_\_\_\_\_  
Chronic Myocarditis  
Chronic Intestinal  
Stenosis

Other conditions (Include pregnancy within 3 months of death) 12/1

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

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Signature] Date signed 5/24/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

00  
17  
19  
03

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.....

**Thomas J. Gates**

working under my personal supervision.

Registered Apprentice No.....

Signed.....



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.