

V. S. No. 2
00M-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15243
4814
State File No.
Registrar's No.

FILED JUN 9 1945

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(c) Name of hospital or institution: Homer G. Phillips Hospital
(d) Length of stay: In hospital or institution 2 Days 21 Hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri
(b) County
(c) City or town St. Louis
(d) Street No. 2213 Franklin
(e) Citizen of foreign country?

3. (a) PRINT FULL NAME Julius Aaron Johnson
(b) If veteran, name war
(c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 3 year 1945 10:00 minute A.M.
21. I hereby certify that I attended the deceased from 12:10 A.M. 5-1 1945 10:00 P.M. 5-1 1945 that I last saw him alive on 5-1 1945 and that death occurred on the date and hour stated above.

4. Sex Male 9
5. Color or race Negro
6. (a) Single, widowed, married, divorced
7. Birth date of deceased: 5 1 45 (Month) (Day) (Year)

Immediate cause of death: Prematurity Atelectosis

8. AGE: Years Months Days If less than one day 2 21 hr. 55 min.

Due to
Due to
Other conditions: (Include pregnancy within 3 months of death)

9. Birthplace: St. Louis Missouri (City, town, or county) (State or foreign country)

10. Usual occupation
11. Industry or business

Major findings: Of operations
Of autopsy
PHYSICIAN Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Johnnie Johnson
13. Birthplace Hinds Ct. Mississippi (City, town, or county) (State or foreign country)
14. Maiden name Effie Coleman
15. Birthplace Sunflower Ct. Mississippi (City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duwell
(b) Address 2601 N. Whittier Street
17. (a) Burial (b) Date thereof MAY 21 1945
(c) Place: burial or cremation CITY CEMETERY

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept
19. (a) MAY 31 1945 (Date received local registrar)
(b) J. F. Bredeck (Registrar's signature)

23. Signature W. S. Linker (M. D. or other)
Address 2601 N. Whittier Date signed 5-17-45

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

206
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.....

Licensed Embalmer No.....

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.