

FRI JUN 30 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5360**

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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 mo. 10 days**
(Specify whether years, months or days)

In this community..... **80 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME..... **George Johnson**

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Widow**

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

7. Birth date of deceased..... **Unknown**
(Month) (Day) (Year)

8. AGE: Years **abt 86** Months **Unknown** Days..... If less than one day hr. min.

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

10. Usual occupation..... **Laborer**

11. Industry or business.....

MOTHER FATHER { 12. Name..... **Unknown**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **Paul Perkins**

(b) Address..... **2819 S. Shadian**

17. (a) **Burial** (b) Date thereof **6/19/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... **J. A. Johnson**

(b) Address..... **2915 Franklin Ave**

JUN 19 1945 (Date) **J. F. Brechee** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County..... **000**

(c) City or town..... **St. Louis,** **21**
(If outside city or town limits, write "RURAL"; (If rural, give location)

(d) Street No. **911 No. Garrison**

(e) Citizen of foreign country?..... **0** (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **15,**
year **1945** hour **2** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **May 5,** 19**45** to **June 15,** 19**45;**
that I last saw h..... **in** live on..... **June 15,** 19**45;**
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Carcinoma of the rectum with metastases**

Due to.....

Due to.....

Other conditions..... **4/6**
(Include pregnancy, within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration.....

Unk.

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)

(c) Means of injury.....

23. Signature..... **B. J. Murphy** M. D.
Address..... **2601 W. 11th St** Date signed **6/15/45**

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

20
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.....

G. A. Allen

Licensed Embalmer No.....

2963

P. O. Address.....

29 N Franklin

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.