

FILED OCT 31 1945

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. _____

8375

1. PLACE OF DEATH

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution St. E. Kraus, Jr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months & days

3. (a) PRINT FULL NAME William J. Johnson

3. (b) If veteran, _____ name war _____ No. _____
3. (c) Social Security _____

4. Sex Male 2. Color Black 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. Age _____ Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Unknown

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown (City, town, or country) _____ (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or country) _____ (State or foreign country)

16. (a) Informant Unknown

(b) Address Unknown

17. (a) Anatomical Board (b) Date thereof 9-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. P. ...

(b) Address 3100 ...

19. (a) SEP 27 1945 (Date received local Registrar's) J. T. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis
(c) City or town St. Louis, Mo.
(d) Street No. 217 E. ... (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Aug day 28 year 1945 hour 8:00 minute am 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 _____

Due to Perforation of Stomach

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 116
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) _____ (e) Means of injury _____

23. Signature Robert G. ... (M. D. or other) _____
Address ... Date signed 9/5/45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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.