S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 10 1945

State File No. 32028

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9341

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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 2705 Howard
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ELLA JOHNSTON

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fem

5. Color or race W

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

6. (b) Name of husband or wife Edwin

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

7. Birth date of deceased Dec (Month) 19 (Day) 1874 (Year)

8. AGE: Years 70 Months 10 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Edward Evans
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Walter Johnson
(b) Address 700 Lincoln Ave., Peoria, Ill.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cem. St. Louis, Mo.

18. (a) Signature of funeral director A. M. McLaughlin
(b) Address 2301 Lafayette Ave., St. Lois, Mo.

19. (a) OCT 29 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th year 1945 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from 10/24/45, 19, to 10/28/45, 19; that I last saw her alive on 10/28/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary artery Thrombosis

Due to

Due to

Other conditions arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Herbert C. Fritz (M. D. or other)

Address 1515 Lafayette Date signed 10/29/45

(Licensed Embalmer's Statement on Reverse Side)

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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.