

FILED DEC 13 1945

Primary Registration District No. 1003

Registrar's No. 10436

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution **Pronounced dead at City Hospital**
(If outside city or town limits, write "RURAL" and name of township)
Franklin Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3**
In this community **about 50 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **over 17**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **4424 Cottage** (If rural, give location) **11**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **DAVID W. JOHNSON**

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

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

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

7. Birth date of deceased **oct 15 1861**
(Month) (Day) (Year)

8. AGE: **84** Months **1** Days **12** If less than one day hr. min.

9. Birthplace **Neirarlands** **For 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Mill**

11. Industry or business.....

MOTHER FATHER { 12. Name **not known** 4
13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name **Not known** 4
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Hall**
(b) Address **4424 Cottage**

17. (a) **Burial** (b) Date thereof **12-1-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J.P. Richardson**
(b) Address **805 E Glasgow**

19. (a) **DEC 1 1945** (b) **J. J. Budeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Nov** 27
year **1945** hour **8** minute **06** A.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**
Coronary Sclerosis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

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?

While at work?..... (Specify type of place) (c) Means of injury **3**
23. Signature **Patricia E. Taylor** (M.D. or other)
Address **Key St** Date signed **11/27/45**

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.