

**FILED DEC 7 1945**  
378

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 20 days  
In this community \_\_\_\_\_ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 21  
(d) Street No. 1214 N Garrison  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth Johnson

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

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Not Known 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Not known  
(Month) (Day) (Year)

8. AGE: Years About 58 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Henderson Miss. (City, town, or county) (State or foreign country)

10. Usual occupation Housekee. per

11. Industry or business Not Known

MOTHER FATHER  
12. Name Miss.  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name Ophelphia McDonell  
15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant Bettie Barnes

(b) Address 1214 North Garrison Avd

17. (a) Shipped (b) Date thereof Dec 1, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jonesboro, Ark.

18. (a) Signature of funeral director A. L. Beal Und Co.

(b) Address 2726 Lucas Ave.

19. (a) DEC 1 1945 (Date of local registrar) J. J. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25  
year 1945 hour 9 minute 40 A. M.

21. I hereby certify that I attended the deceased from 11-6, 1945, to 11-25, 1945.  
that I last saw h. er. alive on 11-25, 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death Manic Reaction with BronchoPneumonia  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Yes

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 0

23. Signature W. J. E. Brown (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier. Date signed 11/28

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 Richardson

Licensed Embalmer No. 2928

P. O. Address City

**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.**