S. No. 2
M—5-43
5-17-39
I X36871

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 35449

Registrar's No. 10334

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 G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days 12 Hrs.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 00-7

(a) State Missouri (b) County 17

(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")

(d) Street No. 3539 Laclede Avenue
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Robert Coleman Johnson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 10 (Month) 31 (Day) 45 (Year)

8. AGE: Years | Months | Days 6 | If less than one day 12 hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Walter Lee Johnson
13. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Lila May Gleason
15. Birthplace Dreston (City, town, or county) Tennessee 1 (State or foreign country)

16. (a) Informant Esther M. Sherard, R.R.d
(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 29 1945 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 7
year 1945 hour 12 minute 55 A. M.

21. I hereby certify that I attended the deceased from 12:55 P. M. 10 - 31 1945 to 12:55 A.M. 11-7 1945
that I last saw him alive on 11 - 7 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Prematurity	
Diarrhea	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 0

23. Signature William H. Inhlen ~~M. D. or other~~

Address 2601 N. Whittier Date signed 11-24-45

(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.....

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: