

#51009
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39336
State File No. 11295
Registrar's No.

FILED JAN 5 1946
318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(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
(If not in hospital or institution, write street number or location) Memorial
(d) Length of stay: In hospital or institution 21 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")
(d) Street No. 4678a Page Blvd.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CHRISTOPHER JOHNS

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 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 December 17 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 --- 3 hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

12. Name Unknown

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Earl F. Johns.

(b) Address 3215 Mitchell Ave., St. Joseph,

17. (a) Burial (b) Date thereof 12 - 24 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director L. S. Stuart
(b) Address 1225 Union Blvd.

19. (a) DEC 24 1945 (b) J. Freden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20th
year 1945 hour 6:30 minute P M.

21. I hereby certify that I attended the deceased from 11/29/45
19, to 12/20/45 19;
that I last saw him alive on 12/20/45 19;
and that death occurred on the date and hour stated above.

Immediate cause of death. Duration

Broncho pneumonia

Due to 107

Other conditions Senile Psychosis simple deteriorating
(Include pregnancy within 3 months of death)

Major findings: 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) Means of injury

23. Signature Philip F. J. Seitz M.D.
1515 Lafayette 12/20/45
(Date signed)

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

MOTHER FATHER

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 John Czaroski
Licensed Embalmer No. 3398
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.