

S. No. 2
DM-2-43
v. 5-17-39
W 1 X39527

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 25 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6969**
Registrar's No. **426**

Registration District No. **377** Primary Registration District No. **3066**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Rockwood**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Highway 66 & Leppington Rd**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **6437 Wellston**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James B Johnson**
(b) If veteran, name war _____ (c) Social Security No. **498-22-0768**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **18** year **1946** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **Nov 23** 19 **45** to **Feb 17** 19 **46**
that I last saw him alive on **Feb 17** 19 **46**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Katherine Johnson** 6. (c) Age of husband or wife if alive **52** years
7. Birth date of deceased **Nov 22** (Month) **1889** (Day) (Year)

Immediate cause of death: **Chronic Myocarditis**
Hypertension
Chronic nephritis
Due to _____
Due to _____
Other conditions: **asthma**
(Includes pregnancy within 3 months of death)

8. AGE: Years **56** Months **2** Days **27** If less than one day _____ hr. _____ min.
9. Birthplace **Iowa** (City, town, or county) (State or foreign country)
10. Usual occupation **Carpenter**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
11. Industry or business _____
12. Name **Richard Johnson**
13. Birthplace **Iowa** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Palmer**
15. Birthplace **Iowa** (City, town, or county) (State or foreign country)
16. (a) Informant **Mrs Katherine Johnson**
(b) Address **6437 Wellston**
17. (a) **Burial** (b) Date thereof **2-21-46** (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation **Oak Hill Cemetery**
18. (a) Signature of funeral director **Louis H. Bopp**
(b) Address **Rockwood, Mo**
19. (a) **2-20-46** (Date received local registrar) (b) **E. D. Harrison** (Registrar's signature)

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 _____ Means of injury _____
23. Signature **Raymond C. McLean M.D.** (M. D. or other) _____
Address **Rockwood Mo** Date signed **7/19/46**

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

6
4
3

0-200

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 Felix Hernandez
Licensed Embalmer No. 3034
P. O. Address Kirkwood mo

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.