

S. No. 2
 DM-5-43
 v. 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
FILED MAR 6 1946 STANDARD CERTIFICATE OF DEATH

State File No. **7593**
1758
 Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County St. Louis
 (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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 mos; 25 days
(Specify whether years, months or days)
 In this community 7 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4144 Finney
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Annie L Johnson
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex Female 5. Color or race Col.
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive 12 years (Month) (Day) (Year)
 7. Birth date of deceased July 12, 1900

8. AGE: Years 45 Months 7 Days 4
 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Eath Vance
 13. Birthplace Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Charlie
 15. Birthplace Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Bean
 (b) Address 1419 N. 16th. Street

17. (a) Burial (Barial, cremation, or removal) (b) Date thereof Feb. 22, 46
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Dale
 18. (a) Signature of funeral director Dement & Son
 (b) Address 2629-31 Coles Street

19. (a) FEB 21 1946 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month February day 16
 year 1946 hour 10 minute 45 PM.
 21. I hereby certify that I attended the deceased from November 23, 1945 to February 16, 1946
 that I last saw h. er alive on February 16, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
Bronchopneumonia
 Due to _____
 Due to _____
 Other conditions (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) (e) Means of injury _____
 23. Signature [Signature] (M. D. number) _____
 Address 2601 N Whittier St. Date signed 2-21-46

Duration
Unk
Unk
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

STATE OF
MISSISSIPPI

DEPARTMENT OF
HEALTH

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

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.

Not embalmed
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.