

V. S. No. 2
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 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 28761

FILED SEP 9 1946

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 7485

1. PLACE OF DEATH:

(a) County _____
 (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 Maternity Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community Infant
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town Hermann
 (If outside city or town limits, write "RURAL")
 (d) Street No. 116 1/2 East Fourth St.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

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3. (a) PRINT FULL NAME Infant Johnson

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 5, 1946
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr. 15 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name George W. Johnson
 13. Birthplace Morrison, Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Lorene Emma Schlemeler
 15. Birthplace Herman, Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant St. Louis Maternity Hospital
 (b) Address 630 S. Kingshighway

17. (a) Anatomical Board (b) Date thereof AUG 31 1946
 (Burial, cremation, or removal) (City, town, or county) (Day) (Year)
Anatomical Board

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutger St

19. (a) AUG 29 1946 (b) J. F. Bredeen
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5th
 year 1946 hour 10:00 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to Atelectasis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. F. Bredeen M.D. (M. D. or other) _____

Address 3720 Washington Date signed 8/29/46

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

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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.