

FILED JAN 7 1946

318

Primary Registration District No. **1003**

Registrar's No. **10979**

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Luther Johnson Exam

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

4. Sex MALE 5. Color or race Col 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased FEB 22 1944
(Month) (Day) (Year)

8. AGE: Years: Months 9 Days 25 If less than one day
2 8 25 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name A.V. Exam

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

14. Maiden name CARRIE JOHNSON

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

16. (a) Informant CARRIE Johnson

(b) Address 3410 Pine St.

17. (a) BURIAL (b) Date thereof DEC 23/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD CEM

18. (a) Signature of funeral director. F A GREEN

(b) Address 2915 FRANKLIN AVE

19. (a) DEC 21 1946 (b) J. F. Bruders
(Date received local registrar) (Registrar's signature)

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. 3410 Pine St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 17
year 1946 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from
Dec. 12, 19 46 to Dec. 17, 19 46
that I last saw him alive on Dec. 17, 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy No

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 Theodore Blevin (M. D. or other)
Address 2601 N. White Date signed 1/18/46

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217
9
9

Duration
Undet.

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

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 *J. A. Green*
Licensed Embalmer No. *2963*
P. O. Address *2915 Franklin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.