

No. 2
5-43
17-39
X36671

Filed District No. 318
Primary Registration District No. 1003

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:
Enroute to Homer G. Phillips 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 2 yrs. years, months or days

3. (a) PRINT FULL NAME Amos T. Johnson
3. (b) If veteran, name war 2
3. (c) Social Security No. _____

4. Sex m 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 9 22 1914
(Month) (Day) (Year)

8. AGE: Years 32 Months 7 Days 10
If less than one day _____ hr. _____ min.

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

10. Usual occupation Foundry Worker
11. Industry or business molder

MOTHER FATHER
12. Name Dead
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace " "
(City, town, or county) (State or foreign country)

16. (a) Informant Alma O'Neil
(b) Address 918 N. 21st Street
(c) Place: burial or cremation Ridgely St. S. Mary
(d) Signature of funeral director Sub Howe
(e) Address 3430 Dickson St.
(f) Date received local Registrar MAY 6 1947

17. (a) Signature of Registrar J. F. Brebeck
(b) Date signed _____
(c) 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. 918 N. 21st.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 2nd
year 1947 hour 10:30 minute _____ P. M.

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

Immediate cause of death gunshot wound of heart inflicted at the hands of private watchman Eddie Johnson
When the deceased showed up Eddie Johnson with a rifle and shot the deceased from a doorway located at 1939 Franklin
Duration of illness _____
Other conditions _____ (Specify pregnancy within 3 months of death)

Major findings: Dead
1947
Of autopsy 16

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) homicide
(b) Date of occurrence May 1, 1947
(c) Where did injury occur? St. Louis
(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 6 above
23. Signature Thomas E. Dwyer (M. D. or other) _____
Address St. Louis Date signed 5/6/47

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

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

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.....

W. Lark Mason
.....
Licensed Embalmer No.....

P. O. Address.....
337
.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. ma 1
Registrar's No. 45919

Registration District No. 218 Primary Registration District No. 1003

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:
(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)

3. (a) PRINT FULL NAME Amos J. Johnson
3. (b) If veteran, name war..... 3. (c) Social Security No. 3

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 32 Months 7 Days 2 (Less than one day) hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER
12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bradest (Registrar's signature)
Date signed

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May Year 1941 hour 12 minute 00 M.
21. I hereby certify that I attended the deceased from 12 to 12 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....
Duration

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

JUN 15 1941

15234

1292-226