

No. 2
-12-45
5-17-39
I X47070

STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15237
1580
Registrar's No.

FILED MAY 14 1947

Registration District No. _____ Primary Registration District No. 1003

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

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: 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
 years, months or days) 20 yrs

3. (a) PRINT FULL NAME Pearl Johnson

3. (b) If veteran, name war None 3. (c) Social Security No. _____

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

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

7. Birth date of deceased August 19 - 1894
(Month) (Day) (Year)

8. AGE: Years <u>52</u>	Months <u>8</u>	Days <u>14</u>	If less than one day hr. _____ min. _____
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9. Birthplace New Port, Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Matron

11. Industry or business _____

MOTHER FATHER { 12. Name Peter Wolley
 { 13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
 { 14. Maiden name Alvania ?
 { 15. Birthplace New Port, Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant William Morant
 (b) Address 465 1/2 Lewis Place

17. (a) Burial (b) Date thereof 5/6/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director C.W. Roberts
 (b) Address 1416 N. Taylor Ave.

19. (a) MAY 5 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(If outside city or town limits, write "RURAL")
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4374 W. Belle Ave
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 2
 year 1947 hour _____ minute 30 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 Arterio Sclerotic Renal
Disease
131a

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 3

23. Signature Patrick E. Taylor (M. D. or other) _____
 Address Deputy Coroner Date signed 5-5-47

[Handwritten signature]

[Handwritten mark]

762138

MAY 6 1947

Embalmer Report Filed

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.