DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15955

FILED MAY 8 1947

Registration District No. 347 Primary Registration District No. 6076 Registrar's No. 987

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jennings (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5404 Fletcher Ave. (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)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Jennings (If outside city or town limits, write "RURAL")

(d) Street No. 5404 Fletcher Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Douglas N. Johnson

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

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henriette Johnson 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 9 (Day) 1888 (Year)

8. AGE: Years 59 Months 1 Days 20 If less than one day ____ hr. ____ min.

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

10. Usual occupation Accountant

11. Industry or business Production Tool & Supply Co.

FATHER
12. Name Henry F. Johnson
13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emma Mengher
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Mrs. Henrietta Johnson

(b) Address 5404 Fletcher Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) 5-3-47 (Date received local registrar) (b) Carl A. J. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30th year 1947 hour 1 minute 25 P. M.

21. I hereby certify that I attended the deceased from Feb 14, 1947, to April 30, 1947 that I last saw h 14 alive on April 30, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary artery disease	3 mo
Due to	
Due to 940	
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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Maurice A. Dickes (M. D. or other) MD

Address 8924 St. Charles Rd Date signed 5/1/47

St. Louis 14, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

MAR 16 1945

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 H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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, above space should be left blank.