S. No. 2
H—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 3 1947
Registration District No. 3 / 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29917
Registrar's No. 1764
Primary Registration District No. 6076

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether
In this community 14 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County ~~Newton~~ Franklin 36
(c) City or town Union 5
(If outside city or town limits, write "RURAL")
(d) Street No. — 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME JOHNS, Leo A.
3. (b) If veteran, name war WW-1
3. (c) Social Security No. 492-14-5037
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced D 3
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 22, 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
54	0	23	hr. min.

9. Birthplace Robertsville, Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation none
11. Industry or business —
FATHER
12. Name William Johns 0
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Liza Jane Kee 0
15. Birthplace Missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Registrar - Veterans Admin-
(b) Address istration Hospital-Jeff.Brks.,Mo.
17. (a) Burial (b) Date thereof 8/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olive Robertsville Mo
18. (a) Signature of funeral director E. G. Oltmann
(b) Address Union Mo
19. (a) 8-16-47 (b) Beula J Sharp MD
(Date received local registrar) (Registrar's signature) MJC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1947 hour 4 minute 00 a M.
21. I hereby certify that I attended the deceased from August 5, 1947, to August 15, 1947;
that I last saw him alive on August 15, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ADENO CARCINOMA OF STOMACH	
Due to	
Due to 46 b	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) none
(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? 0
(Specify type of place)
While at work? (e) Means of injury
23. Signature Wm F. Rose (M. D. or other) MD
Wm. F. ROSE, M.D.
Address VAH, Jeff.Brks, Mo. Date signed 8/15/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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: E. A. Oltmann

Licensed Embalmer No. 1686

P. O. Address Union Mo.

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.