

No. 2
1/47
5-17-39

FILED JAN 9 1948
318

Registration District No.
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St. Louis MO**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **City Infirmary Hosp**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **7/14/43 to 12/27/47**
(Specify whether In this community..... years, months or days)

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. **5800 Arsenal St**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **John Johnson**

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex **Colored** race **Male** 5. Color or race.....

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife.....

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

7. Birth date of deceased **Jan. 17 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	11	10hr.min.

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

10. Usual occupation **Nil**

11. Industry or business.....

12. Name **Unknown**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmary Records**

(b) Address **5800 Arsenal St**

17. (a) **Buried** (b) Date thereof **1-5-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or removal **Municipal Cemetery - City Infirmary**

18. (a) Signature of funeral director **5800 Arsenal**

(b) Address.....

19. (a) **JAN 5 1948** (b) **J. F. Buresk**
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **27**, year **1947** hour **8** minute **A** M.

21. I hereby certify that I attended the deceased from **1/1** 19**47** to **12/27** 19**47**, that I last saw him **in** alive on **12/27** 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death: **Chromosomal bronchopneumonia**
multiple cerebral vascular accidents
Generalized arteriosclerosis
Other conditions: activity with mental deterioration

PHYSICIAN: **S. H. B.**

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).....

(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 **M. P. Shoney** (M. D. or other) **0**
Address **5800 Arsenal** Date signed **12-27**

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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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 18096

Registration 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:
(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 John Johnson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Jan 17 1918
(Month) (Day) (Year)

8. AGE: Years 21 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace St. Louis
(City, town, or county) (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____ Year 1948 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ to _____ 19____; that I last saw him/her on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

43109

HT
2700