

S. No. 300  
DM-10-47  
5-17-39  
I 3506

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14273  
14373  
State File No. 4105  
Registrar's No.

FILED MAY 11 1948

Registration District No. 318

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  
(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 13 days  
(Specify whether in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Robert Johnson

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color of race Col 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Georgia Johnson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 8 12 1882  
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ridgeway S.C.  
(City, town, or county) (State or foreign country)

10. Usual occupation Truck Helper

11. Industry or business \_\_\_\_\_

12. Name Jack Johnson

13. Birthplace S.C.  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown  
(City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Georgia Johnson

(b) Address 1327 Blair St

17. (a) Burial (b) Date thereof 5-1-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Gus Lowe

(b) Address 2930 Dickson St.

19. (a) APR 30 1948 (b) J. P. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 1347 Blair (If rural, give location) 9

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1948 hour 8 minute 10 a.m.

21. I hereby certify that I attended the deceased from April 13 1948 to April 26 1948.  
that I last saw him alive on April 26 1948.  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Aortic Aneurysm with Atelectasis of right lower lung

Due to \_\_\_\_\_

Due to MI

Other conditions R. O. Bronchogenic Carcinoma  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature Ossey P Daniels (M. D. or other) 17/16/48

Address 2601 W. Wheeler Date signed \_\_\_\_\_

Duration  
Physician  
Underline the cause to which death should be charged statistically.

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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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4049 St. Ferdinand

**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.**