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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JUN 21 1948

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

21008

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5210**

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:
St. Anthony's Hospital 0
(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 **Infant Johnson (Twin)**
3. (b) If veteran, name war: **None**
3. (c) Social Security No. **None**

4. Sex **Male** 0
5. Color or race **White**
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 **May 23, 1948**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 14 hr. min.

9. Birthplace **St. Louis, Missouri** 0
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER {
12. Name **Otho Johnson**
13. Birthplace **Washington** /
(City, town, or county) (State or foreign country)
14. Maiden name **Moselle Fears**
15. Birthplace **Arkansas** /
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Otho Johnson**
(b) Address **3301 Texas**

17. (a) **Burial** (b) Date thereof **6-7-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cemetery Southern Funeral Home**
18. (a) Signature of funeral director _____
(b) Address **6322 S. Grand Blvd.**

19. (a) **1122 7** (b) **J. F. Brebeck**
(Date of local registrar) (Registrar's signature)

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. **3301 Texas** (If rural, give location)
24
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **7th**
year **1948** hour **9** minute **30 a.m.**

21. I hereby certify that I attended the deceased from **May 23, 1948** to **June 7, 1948**
that I last saw him alive on **June 6, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory Paralysis** Duration **2 days**
Due to **Cerebral Hemorrhage** **100%**

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 _____

23. Signature **Oliver Johnson** (M. D. or other) **MD**
Address **2606 Hurby** Date signed **June 7-48**

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

1112-80
1149

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 J. Wm Binkley
Licensed Embalmer No. 3653
P. O. Address St. Louis, 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.