

3-300
10-47
17-39
I 3906

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

#7201
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 2 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **10189**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis, Missouri.
(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. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME ARCHIE JOHNSON
3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Late Fredericka
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 30 1864
(Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 23
If less than one day _____ hr. _____ min.

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

10. Usual occupation Wholesale Grocer Clerk
(Retired)

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Scotland
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown
15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant John Johnson
(b) Address 5054a Parker

17. (a) Burial (b) Date thereof 11-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Gardens

18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 So. Kingshighway Bl.

19. (a) NOV 24 1948 J. B. Larsten
(Date received local registrar's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County _____
(c) City or town St. Louis Compton Ave.
(If outside city or town limits, write "RURAL")
(d) Street No. 1823 So. Compton Ave.
Memorial (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 23rd
year 1948 hour 7 minute 15 A.M.
21. I hereby certify that I attended the deceased from 11/21/48
to Nov. 23rd 19 48
that I last saw him alive on Nov. 23rd 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
Due to thrombophlebitis of st. lower extremity
Due to _____

Other conditions (include pregnancy within 3 months of death) no

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)
(c) Means of injury _____

23. Signature Thos. S. Bryan (M. D. or other)
Address 1515 Lafayette 11/23/48
Date signed

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

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 Richard W. Stovesand

Licensed Embalmer No. 4007

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.