

FILED FEB 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2848  
544

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>8 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>900 R. Kemp Cass Ave</u>				d. STREET ADDRESS (If rural, give location) <u>908 R. Cass Ave.</u>					
3. NAME OF DECEASED (Type or Print) <u>Alex</u>			a. (First) _____	b. (Middle) _____	c. (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 15 49</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>11-28-1895</u>			
9. AGE (In years last birthday) <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mattress maker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Utica Miss</u>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>Jonas Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Susie Taylor</u>			
13c. NAME OF HUSBAND OR WIFE <u>Mannie Johnson</u>		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes wart</u>		16. SOCIAL SECURITY NO. <u>500-24-7557</u>			
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mannie Johnson</u>		17. INFORMANT'S SIGNATURE OR NAME		17. INFORMANT'S SIGNATURE OR NAME		ADDRESS <u>908 R. Cass</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Labor Pneumonia</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>490* / 100</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1-10</u> 19 <u>49</u> , to <u>1-10</u> 19 <u>49</u> that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8 A m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>S. W. Wilkeason M.D.</u>				23b. ADDRESS <u>4141 Page</u>		23c. DATE SIGNED <u>1-17-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>1-22-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brunwood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>JAN 19 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lanster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gus Lowe 2930 Dickson St.</u>					

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

MAR 29 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Arthur L. Hilliard

Signed .....  
Student Embalmer

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.