

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21229**  
**4872**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. <b>1003</b>	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>25 1925 Chouteau Ave.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Virginia</b>		b. (Middle) _____		c. (Last) <b>Johnson</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>May 29, 1949</b>				
5. SEX <b>Female-3</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3 - 6 - 1906</b>	9. AGE (In years last birthday) <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Greenville, Mississippi.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Crawford Jones</b>		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE <b>Johnnie Johnson</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Johnnie Johnson</b> ADDRESS <b>1925 Chouteau Ave.</b>
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, asthma, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prob. Dissecting Aneurysm of Aorta</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Broncho-pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>St. Louis Mo.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>022X</b>
22. I hereby certify that I attended the deceased from <b>5-27</b> , 19 <b>49</b> , to <b>5-29</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>5-29</b> , 19 <b>49</b> , and that death occurred at <b>10:55 p.m.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Walter Daniels</b>		23b. ADDRESS <b>2601 N Whittier St</b>		23c. DATE SIGNED <b>6-1-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6 - 4 - 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>				
DATE REC'D BY LOCAL REG. <b>JUN 3 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Laster</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellis Funeral Home, 2820 Stoddard St.</b>

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

**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.

Student .....  
Student Embalmer

Signed *Fulton E. Culkin*

Licensed Embalmer No. *498*

P. O. Address *St Louis 13. 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.