

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28205

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7223

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>23-1814 KENNETT PLACE</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRED</u>	b. (Middle) <u>S.</u>	c. (Last) <u>JOHNSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 1 1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 29 1888</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>3</u> Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>SAMUEL JOHNSON</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE TUCKER</u>	14. NAME OF HUSBAND OR WIFE <u>ETHEL JOHNSON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ETHEL JOHNSON 1814 KENNETT</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sub-dural and epi-dural hemorrhage of the brain</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>principally over the cerebellum</u>		
DUE TO (c) <u>Time, place, cause and manner of same could not be determined.</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>open verdict</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>open verdict</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) <u>St. Louis MO</u>
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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? <u>321X</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <u>Patrick E. Taylor MD</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>9-2-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>SEPT. 3 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER + PAUL</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
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DATE REC'D BY LOCAL REG. <u>SEP 2 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Casate</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kurtz 2906 Morris</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

grilled

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 Leo J. Budd _____

Licensed Embalmer No. 3989 _____

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.