

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6267  
1473

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
 a. COUNTY \_\_\_\_\_  
 b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis MO.  
 c. LENGTH OF STAY (In this place) \_\_\_\_\_  
 d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
 a. STATE Missouri  
 b. COUNTY \_\_\_\_\_  
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  
 d. STREET ADDRESS (If rural, give location) 7728 East Railroad St.

3. NAME OF DECEASED  
 a. (First) John  
 b. (Middle) L  
 c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year)  
Feb. 10 1950

5. SEX Male

6. COLOR OR RACE Col.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH August, 4th, 1871

9. AGE (In years last birthday) 78

If UNDER 1 YEAR Months 6 Days 6

If UNDER 24 HRS. Hours 6 Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling

10b. KIND OF BUSINESS OR INDUSTRY Selfemployd

11. BIRTHPLACE (State or foreign country) Kentucky, State

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John L. Johnson SR;

13b. MOTHER'S MAIDEN NAME Cellia Washington

14. NAME OF HUSBAND OR WIFE Lillie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Russell Johnson 1817 Carr St.

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.

MEDICAL CERTIFICATION  
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Aortic Valvular Heart Disease  
 ANTECEDENT CAUSES Probably arteriosclerotic in origin  
 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. None

INTERVAL BETWEEN ONSET AND DEATH  
Undet.

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

21a. ACCIDENT (Specify) \_\_\_\_\_  
 SUICIDE \_\_\_\_\_  
 HOMICIDE \_\_\_\_\_

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  
H. 241

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK?  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 1-29, 1950, to 2-10, 1950, that I last saw the deceased alive on 2-10, 1950, and that death occurred at 2:24 m., from the causes and on the date stated above.

23a. SIGNATURE James T. Hedrick (Degree or title) \_\_\_\_\_

23b. ADDRESS 2601 N Whittier St

23c. DATE SIGNED 2-10-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 2/18/50

24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis Missouri

DATE REC'D BY LOCAL REG. FEB 14 1950

REGISTRAR'S SIGNATURE J. B. Santos

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Price & Dozier 2829 Washington Blvd

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

*mul*

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

working under my personal supervision.

Signed.....  
Student Embalmer

Signed *J. A. [Signature]*  
Student Embalmer No. ....  
Licensed Embalmer No. *4441*  
P. O. Address. *2829 Washington*

**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.