

FILED JUL 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21667  
State File No. 5776  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>314 So Harrison</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>PHILLIPS HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Laura</b>	b. (Middle)	c. (Last) <b>Johnson</b>	4. DATE OF DEATH (Month) (Day) (Year)
				<b>June 30 1950</b>

5. SEX <b>F</b>	6. COLOR OF FACE <b>3 Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow 2</b>	8. DATE OF BIRTH <b>Unknown 68</b>	9. AGE (in years) (months) (Days) (Hours) (Min.)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during major working life, even if retired) <b>mt</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Unknown 9</b>	12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE
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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 <b>F. A. Green - 4214 Delmar</b>
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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) <b>Hypertensive Cardiovascular Disease</b>		<b>Undet.</b>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebrovascular Disease</b>		<b>Undet.</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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? <b>HH 3X</b>
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22. I hereby certify that I attended the deceased from **6-26**, 19**50**, to **6-30**, 19**50**, that I last saw the deceased alive on **6-30**, 19**50**, and that death occurred at **8:39a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Montague Lawrence</b>	23b. ADDRESS <b>2601 N Whittier St</b>	23c. DATE SIGNED <b>7-1-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>July 6/50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Dale Cem</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis MO</b>
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DATE REC'D BY LOCAL REG. <b>JUL 3 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Farster</b>	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <b>4214 Delmar F. A. Green</b>
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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

*F. C. Green*

Licensed Embalmer No.

*2963*

P. O. Address

*4214 Delmar*

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.