

FILED OCT 26 1954

STANDARD CERTIFICATE OF DEATH

State File No. **35531**  
Registrar's No. **8866**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **218** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		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 OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Homer G. Phillips Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1316 Hadley</b>	<b>225/6</b>

3. NAME OF DECEASED (Type or Print) a. (First) <b>Frankie</b> b. (Middle) _____ c. (Last) <b>Johnson</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9 14 54</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>11-1-1918</b>	9. AGE (In years last birthday) <b>35</b>	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 MIN. Hours	# UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>Louisiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>?</b>	13b. MOTHER'S MAIDEN NAME <b>?</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Julia E. Mosley, Med. Dir. Office</b>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis Far Advanced</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>
	ANTECEDENT CAUSES Morbidity 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>Acute Brain Syndrome with Metabolic Disturbance</b>		<b>Dis</b>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>002x</b>

22. I hereby certify that I attended the deceased from **8-18**, 19**54**, to **9-14**, 19**54**, that I last saw the deceased alive on **9-14**, 19**54**, and that death occurred at **1:23 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>N. J. Ekman M.D.</b>	23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>9-21-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <b>9-30-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Burial</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 30 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith Mo</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland-Aker Mortuary Service</b>	ADDRESS <b>4104 Manchester Ave. St. Louis 10, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.