

FILED MAR 31 1955

STANDARD CERTIFICATE OF DEATH

State File No. 9791

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2111

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 3522 Cozens	
3. NAME OF DECEASED (Type or Print) a. (First) Jim		b. (Middle)	
c. (Last) Johnson		4. DATE OF DEATH (Month) 3 (Day) 6 (Year) 55	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH June 25, 1895	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Mon 9 Day 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. car cleaner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Monroe, La.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Johnson		13b. MOTHER'S MAIDEN NAME Cora Golstar	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes	
16. SOCIAL SECURITY NO. 489614664507		17. INFORMANT'S SIGNATURE OR NAME Annie Johnson	
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, ashenia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Encephalopathy Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertension Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH Undt.		19. 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)		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? 331X	
22. I hereby certify that I attended the deceased from 3-1, 1955, to 3-6, 1955, that I last saw the deceased alive on 3-6, 1955, and that death occurred at 3:40 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Edw. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 3-7-55		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 36 10 55		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Co Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS etis Funeral Home 4181 Washington	
DATE REC'D BY LOCAL REG. MAR 7 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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.....
Signature of Student Embalmer

Signed *Escher H. Harris*

Licensed Embalmer No. *44*

P. O. Address *4181 Main*

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.