

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

41192

1. PLACE OF DEATH

98 County Randolph
Township Silver Creek
City (No.) St. Ward)

Registration District No. 731
Primary Registration District No. 5973

File No.
Registered No.

2. FULL NAME

Clarence Kim Johnson

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1932

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1932, to Dec 24, 1932, that I last saw him alive on Dec 24, 1932, and that death occurred, on the date stated above, at 6 0 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-4-1909

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>23</u>	<u>3</u>	<u>20</u>	

Postal shot in Right Temple.
Self inflicted

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Horse Trainer
(b) General nature of industry, business, or establishment in which employed (or employer) 219
(c) Name of employer

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chariton Co, Mo

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH ①

10. NAME OF FATHER Frank Johnson

DID AN OPERATION PRECEDE DEATH? DATE OF

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Amanda Elliot

WHAT TEST CONFIRMED DIAGNOSIS

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

(Signed) W. E. Alvarado M. D.

, 19 (Address) Clifton Hill Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address) Frank Johnson
Clifton Hill Mo

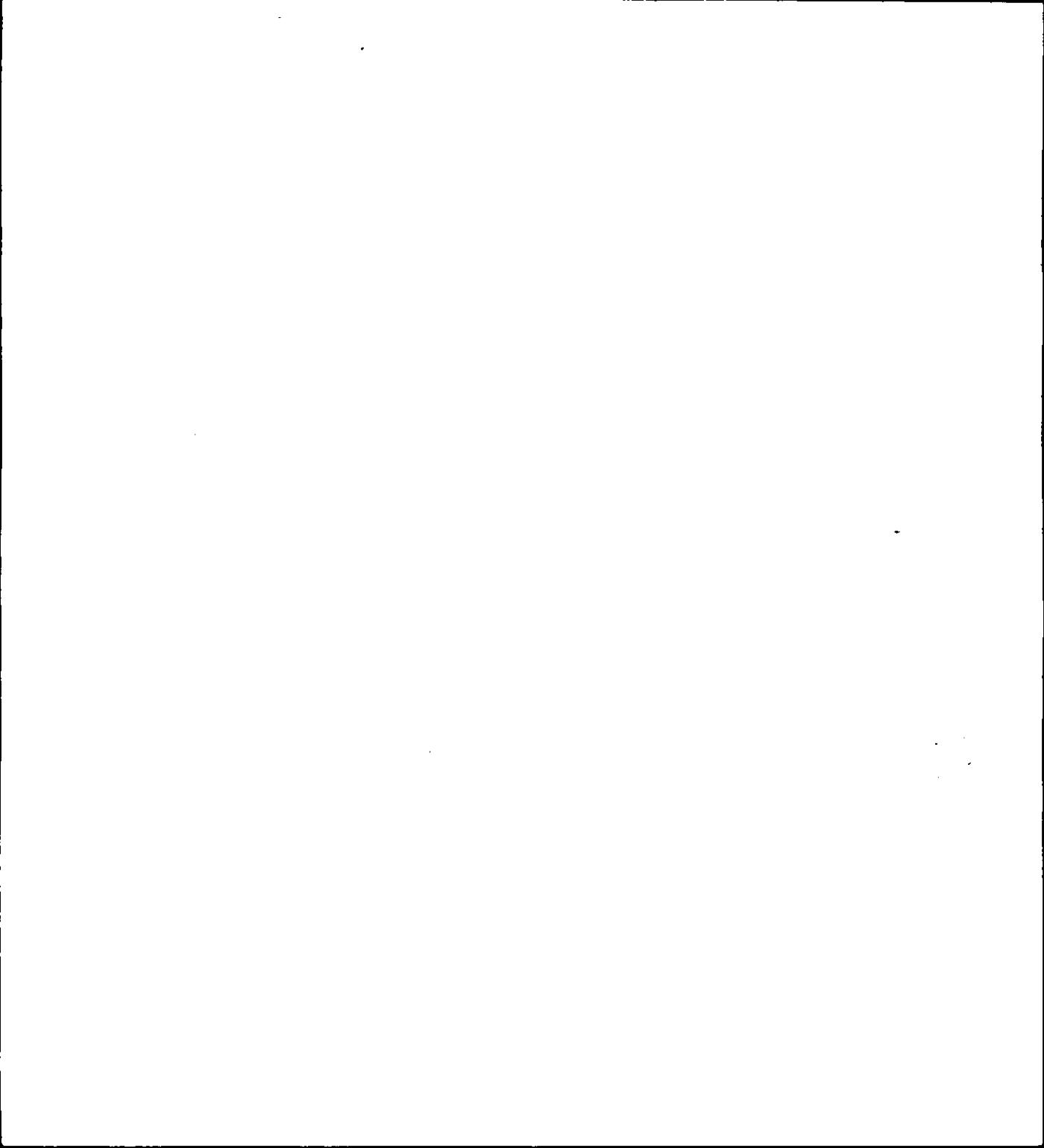
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Asbury Cemetery 12-26-1932

15. FILED 1-3 1933 Mary J. Shives REGISTRAR

20. UNDERTAKER ADDRESS
Winkelmeier Bros Salisbury

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AN 27 1933



order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Larence Frank Johnson

Who died at Randolph Co. on Dec. 24, 1932
(City) (County) (Date)

Residence: No. _____ St. _____
(if nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month 16 Year 1932

Birthplace (State or Country) _____

Birthplace of father (State or Country) _____

Birthplace of mother (State or Country) _____

Principal cause of death: Pistol shot in right temple self-inflicted.

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? suicide Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town county and State)

Specify whether injury occurred in industry, in home, or in public place.
occurred in father's home

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____



S-41192