

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

32482
Do not use this space.

REC'D OCT 1 1939

1. PLACE OF DEATH
 (a) County Henry 3 Registration District No. 347
 (b) Township _____ Primary Registration District No. 3018 Registered No. _____
 (c) City Clinton 1 (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Frank Johnson
 (a) Residence, No. Don't Know (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Don't Know
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't Know
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Head Peace
9. Industry or business in which work was done, as saw mill, bank, etc. Salesman
10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know
FATHER
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) F. B. D. D. C.
18. BURIAL, CREMATION, OR REMOVAL PLACE Englewood DATE 9/15/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Consolidated
20. FILED 9-23 1939 Dr. J. R. ... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 10 1939
22. I HEREBY CERTIFY That I attended deceased from _____ 1939 to Sept 10 1939
 I last saw him alive on Sept 10 1939. Death is said to have occurred on the date stated above, at 1:55 pm.
 The principal cause of death and related causes of importance were as follows:
Skull fracture from falling from moving train Date of onset Sept 10/39
 Other contributory causes of importance: None
 Name of operation none Date of _____
 What test confirmed diagnosis? Examined Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury Sept 10 1939
 Where did injury occur? Clinton, Henry Co., MO.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. on railroad track
 Manner of injury Fall from moving train
 Nature of injury Skull fracture
24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) S. B. Hughes M. D.
 (Address) Corner Hwy 9, Clinton, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISTRICT OF COLUMBIA
HEALTH DEPARTMENT

RECEIVED

RECEIVED
District Health Officer No. 7,
District File Number 7-39-1370
Date Filed 10-7-39

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,

J. E. Consolus

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

J. E. Consolus

Licensed Embalmer No.

1891

P. O. Address

Clinton 400

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Henry Registration District No. 347
(b) Township Clinton Primary Registration District No. 3018 Registered No. _____
(c) City Clinton (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank Johnson
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
app 40

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 9-23 1939 D. J. R. Hampton Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____, 19____
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
skull fracture fell from moving train (Date of onset)

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ 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. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) S. B. Hughes M. D.
(Address) Surgeon

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly understood

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

