

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 85

1. PLACE OF DEATH:

FILED FEB 12 1940

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
415 N. 19th Str.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph Street  
(If outside city or town limits, write "RURAL")  
(d) Street No. 415 N. 19th Street.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? Unknown years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Herbert Johnson 525

3. (b) If veteran, name war Unknown 3. (c) Social Security No. 491-09-9348

20. DATE OF DEATH: Month Jan. day About 24th  
year 1940 hour Unknown minute M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased October 5 1892  
(Month) (Day) (Year)

21. I hereby certify that I viewed the deceased from Jan 26th 19 40 to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw ~~the deceased~~ viewed \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Duration

8. AGE: Years 47 Months 3 Days 19 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Unknown Sweden  
(City, town, or county) (State or foreign country)

Other conditions none  
(Include pregnancy within 3 months of death)

10. Usual occupation Cabnit Maker

Major findings:  
Of operations \_\_\_\_\_

11. Industry or business Collier - Adams

Of autopsy none

12. Name Unknown

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant Records Collier-Adams

(b) Address St. Joseph, Missouri.

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof Jan. 29, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Hereward W. Biedenfader

(b) Address 1802 Union Str. St. Joseph, Mo.

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

19. (a) Jan. 29, 1940 (b) A. J. Neathus  
(Date received local registrar) (Registrar's signature)

23. Signature B. W. Tadlock (M. D. or other) 1 coroner

Address King Hill Bldg. Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Signed *Robert C. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

**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.**