

FILED APR 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10724

Dr. Rambo

Registration District No. 213

Primary Registration District No. 5293

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town R.F.D. #2 - Jeff City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
R.F.D. #2, Jefferson City, Mo
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Claude N. Johnson 525

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sara Catherine Johnson 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased May 1 1886
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>10</u>	<u>26</u>	hr. _____ min.

9. Birthplace Walnut, Kansas
(City, town, or county) (State or foreign country)10. Usual occupation Prison Guard

11. Industry or business _____

MOTHER FATHER
 { 12. Name Jonaths Johnson
 13. Birthplace Not Known
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant Miss Sara C Johnson(b) Address Jefferson City, Missouri17. (a) Removal (b) Date thereof Mar 24 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Maple Hill Mo18. (a) Signature of funeral director W. G. Gaden(b) Address Jefferson City Mo19. (a) Indy 28.40 (b) J
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
 (c) City or town Jefferson
 (If outside city or town limits, write "RURAL")
 (d) Street No. R.F.D. #2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1940 hour 5 minute P. M.21. I hereby certify that I attended the deceased from Nov 26
Feb. 18 1940 to Feb 18 1940;
that I last saw him alive on March 26 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to mitral stenosis
(chr cardiac)

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (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? _____

23. Signature W. W. Rambo (M. D. or other) M.D.
 Address Jeff City Mo Date signed 3/28/40

(Licensed Embalmer's Statement on Reverse Side)

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

26

MISSOURI DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
J

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 *Walter J. Gordon*
Licensed Embalmer No. *1286*
P. O. Address *Jefferson City 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10724

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 213

Primary Registration District No. 2293

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Cole
(b) City or town Jefferson (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Claude N. Johnson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 88 Months 10 Days 26 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/28/40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature W. A. Rambo (M. D. or other) _____

Address Jeff City Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-10724

1940