

FILED APR 27 1940

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

10778  
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 241  
 (b) Township N. Benton Primary Registration District No. 5534  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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

James Calloway Johnston  
 (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

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 Cora Johnson  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 16 - 1870  
 7. AGE YEARS 69 MONTHS 6 DAYS 20 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. carpenter  
 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) Jenn

FATHER 13. NAME Wm Johnson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atlanta Ga

MOTHER 15. MAIDEN NAME Mary Ann Dean

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jenn

17. INFORMANT Haisy Johnson (ADDRESS) Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 3-9 1940

19. FUNERAL DIRECTOR (NAME) F. B. Jones (ADDRESS) Buffalo Mo

20. FILED 3/20 1940 Harvey Morrow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7 1940

22. I HEREBY CERTIFY, That I attended deceased from 1-30 1939 to 3-7 1940  
 I last saw ~~her~~ alive on 3-7 1940. Death is said to have occurred on the date stated above, at 27 m.  
 The principal cause of death and related causes of importance were as follows:

Diabetic Mellitus

Date of onset (?)

54

Other contributory causes of importance: Broncho Pneumonia

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? no

If so, specify \_\_\_\_\_ (Signed) R. E. Howell \_\_\_\_\_ M. D.  
 (Address) Buffalo, Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

FORM 9-19-38  
 I X 16605

RECEIVED  
District Health Officer No. *T<sub>2</sub>*  
District File Number *H-40-514*  
Date Filed *4-1-40*

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**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.....  
Licensed Embalmer No.....  
P. O. Address.....

**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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 10778

Registration District No. 241

Primary Registration District No. 5334

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Dallas

(b) City or town. Centon rural  
(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 James Alloway

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, if alive. year

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

8. AGE: Years Months Days If less than one day

69 6 20 hr. min.

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

10. Usual occupation.

11. Industry or business.

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)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Waller

(c) City or town. Buffalo Mo  
(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.

20. DATE OF DEATH. Month 3 day 7 year 1940 hour. minute. M.

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

Immediate cause of death. Duration

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 R. E. Harrell (M. D. or other) Address Buffalo Mo Date signed

SUPPLEMENTARY

MOTHER FATHER

S-10778

1940