

WHITE PENCIL—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. Simpson 15375

State File No. \_\_\_\_\_

Registration District No. 446

Primary Registration District No. 3020

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield

(c) Name of hospital or institution: 221 N. Caldwell St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 years  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Harvey Burns Johnson

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. 525

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth Johnson

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Aug 13-1860  
(Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Rowan County - Ky  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Phelps Johnson

13. Birthplace Rowan County - Ky  
(City, town, or county) (State or foreign country)

14. Maiden name Louetta Logan

15. Birthplace Rowan County - Ky.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. A. D. Johnson

(b) Address Brookfield

17. (a) Burial (b) Date thereof 4/14/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ross Hill Cemetery Brookfield

18. (a) Signature of funeral director Hills Chapel

(b) Address Brookfield Mo. 445

19. (a) April 13 40 (b) J. W. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Brookfield  
(If outside city or town limits, write "RURAL")

(d) Street No. 221 N. Caldwell  
(If rural, give location)

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12  
year 1940 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from August, 1937, to April 12 1940  
that I last saw him alive on April 11, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis Duration 3 years

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

Due to 12/1

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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. B. Simpson (M.D. or other) MD  
Address Brookfield Mo Date signed 4/13/40  
(Specify type of place) (e) Means of injury \_\_\_\_\_

**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.....

*J. W. Blacklock*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *J. W. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield, 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.**