

Registration District No. 460

Primary Registration District No. 5623 4213 Registrar's No. 20

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Dover
(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 LENARD JOHNSON ⁵²⁵

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

4. Sex ma 5. Color or race colored 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 8 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 2 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Lenard Johnson

13. Birthplace not known
(City, town, or county) (State or foreign country)

14. Maiden name Lena Combs

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

16. (a) Informant's own signature Lena Johnson

(b) Address Dover, Mo

17. (a) Burial (b) Date thereof April 8-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dover, Mo

18. (a) Signature of funeral director Winters

(b) Address Lexington, Mo

19. (a) 6-2-40 (b) T. Jeffrey Webb
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette
(c) City or town Dover, 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day april
year 1940 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from 4-8-1940 to 4-8-1940, 1940
that I last saw him alive on _____, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia Left Lung Duration _____

Due to (Coroner's Case)

Due to _____

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

Major findings: Of operations _____

Of autopsy Labor Pneumonia Left Lung ¹⁰

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? 41

(e) Means of injury _____ (Specify type of place)

While at work? _____

23. Signature [Signature] (M. D. certificate) _____

Address Adessa Mo Date signed 4/8/40

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.

RECEIVED
District Health Officer No. 8,
District File Number
6-4-40
Date Filed

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.