

FILED JUL 17 1940

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

21615

Do not use this space.

## 1. PLACE OF DEATH

(a) County Callao Registration District No. 247  
 (b) Township Wilson Primary Registration District No. 5343 Registered No. 8  
 (c) City ..... (d) Street No. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (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

(a) Residence, No. 525 Cordelia C. Johnson  
Long Lane Dr. R F D.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unwedded

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Johnson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 26 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 | 10 | 3

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
 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) Marysville Mo.

FATHER  
 13. NAME Unknown

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

MOTHER  
 15. MAIDEN NAME .....

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

17. INFORMANT (ADDRESS) Mrs James C. Smith  
Phillipsburg Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE New Hope DATE 3-1 1940

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

20. FILED, 7-9- 1940 L. N. Talbot Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29 1940

22. I HEREBY CERTIFY, That I attended deceased from 3-26 1940, to 3-29 1940

I last saw him alive on 3-26 1940 Death is said to have occurred on the date stated above, at 9:40 a.m.

The principal cause of death and related causes of importance were as follows:

Hemorrhage of brain Date of onset

Other contributory causes of importance:

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) J. W. Hindray, M. D.  
224 Address) Courtesy

RECEIVED  
District Health Officer No. 7.  
District File Number 7-20-1078  
Date Filed 7-17-40

**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. 21615-  
Registrar's No. 8

Registration District No. 247

Primary Registration District No. 5343

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

1. PLACE OF DEATH:

(a) County Dallas  
(b) City or town Wilson  
(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 Cordelia C. Johnson

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased may 26 1879  
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 3 If less than one day \_\_\_\_\_ 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 there mar 1 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 5-16- (b) L. W. Falbo  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas  
(c) City or town Phillipsburg 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 3 day 29  
year \_\_\_\_\_ 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 \_\_\_\_\_

Duration

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? \_\_\_\_\_

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

23. Signature J. W. Lindsay (M. D. or other) \_\_\_\_\_

Address Conway Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

