

FILED AUG 9 1940

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

25206

State File No. _____

Registration District No. 318Primary Registration District No. 2001Registrar's No. 597

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. John Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Ina May Johnson 5258. (b) If veteran, name war no 8. (c) Social Security No. no4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife J.H. Johnson 6. (c) Age of husband or wife if alive 56 years7. Birth date of deceased July 6 1884
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
✓ 56 0 12 hr. min.9. Birthplace: Stuben County Indiana
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name of Wm. McElhanev13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)14. Maiden name Carolyn Claire15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)16. (a) Informant J.H. Johnson(b) Address Springfield, Mo.17. (a) Burial (b) Date thereof July 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Greenlawn18. (a) Signature of funeral director W.H. Lohmeyer(b) Address Springfield, Mo.19. (a) July 21, 1940 (b) W. E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene(c) City or town Springfield
(If outside city or town limits, write "RURAL")(d) Street No. 1201 State
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1940 hour 9 minute 40 a. m.21. I hereby certify that I attended the deceased from July 2-1940
to July 18, 1940
that I last saw her alive on July 18, 1940
and that death occurred on the date and hour stated above.Immediate cause of death
Paralytic ileus and
anuria - post operative Duration 4 daysDue to Hunger of Bowel due toDue to Carcinoma of Cecum
with partial obstructionOther conditions _____
(Include pregnancy within 3 months of death) 46Major findings: Carcinoma of CecumOf operations primary seat

Of autopsy _____

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 A. D. Hall (M. D. or other) M.D.Address Springfield Mo Date signed 7/19/40

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.