

Registration District No. **85**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
 (c) Name of hospital or institution: 1415 Charles
 (If not in hospital or institution, write street number or location) 2
 (d) Length of stay: In hospital or institution _____
 In this community 69 years 7 months 24 days
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT JOHNSON 525
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife FRANCES
 6. (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased Dec. 30, 1870
 (Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 24
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER {
 12. Name Drury Johnson
 13. Birthplace unknown Illinois
 (City, town, or county) (State or foreign country)
 14. Maiden name Martha Holloway
 (City, town, or county) (State or foreign country)
 15. Birthplace Madison City, Ky.
 (City, town, or county) (State or foreign country)

16. (a) Informant Charles E. Johnson
 (b) Address R.R. # 2, St. Joseph, Mo.

17. (a) burial (b) Date thereof 8-26-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Fleeman & Son, Inc.
 (b) Address St. Joseph, Missouri

19. (a) 8/26/40 (b) W. Nestleberg
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL") Rural
 (d) Street No. R.R. # 2
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 24th
 year 1940 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Aug 21st, 1940, to Aug 24, 1940
 that I last saw him alive on Aug 23rd, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage (apoplexy) 3 days
 Duration

Due to probably Hypertension and Arterio-sclerosis not known

Due to _____
 Other conditions § 211
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations No operation
 Of autopsy No autopsy made
 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? § 5

While at work? _____ (e) Means of injury _____

23. Signature William A. Robertson (M. D. or other) M.D.
 Address 6210 1/2 King Hill Ave. Date signed Aug 25-40

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 Carl W. Haus
Licensed Embalmer No. 3955
P. O. Address St. Joseph, 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, fact should be so stated above.