

No. 9
17-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31721**

OCT 12 1940

Registration District No. **184** Primary Registration District No. **5257** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Christian** **Lynn, Mo.**
(b) City or town **Rural** **Len township**
(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 **2**
In this community **One year** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sarah K. Johnson**

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

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Lewis H. Johnson** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 16 1891** (Month) (Day) (Year)

8. AGE: Years **69** Months **2** Days **8** If less than one day hr. _____ min. _____

9. Birthplace **Ray County Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business _____

MOTHER { 12. Name **Unknown**
13. Birthplace **Unknown** (City, town or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Lewis H. Johnson**
(b) Address **Sparta Missouri**

17. (a) **burial** (b) Date thereof **Sept 25 1940** (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Chadwick**

18. (a) Signature of funeral director **Denver Roller**
(b) Address **ava mo**

19. (a) _____ (b) **Loretta Leonard** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Christian**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Len township** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **24**
year **1940** hour **10** minute **25 A. M.**

21. I hereby certify that I attended the deceased from **Sept 10**
1940 to **Sept. 24**, 19 **40**
that I last saw her alive on **Sept 24**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Organic Heart Disease**

Due to _____

Due to _____

Other conditions **none** (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

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? **170** (Specify type of place) (a) Means of injury _____

23. Signature **Engene B. Munnick** D. or other _____
Address **Chadwick Mo** Date signed **9-25-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Timothy A. ...

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 _____

Denver Roller

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed *Denver Roller*

Licensed Embalmer No. *4006*

P. O. Address *Ava, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31721

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 184

Primary Registration District No. 3257

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Christian
(b) ~~City or town~~ Lebanon, Mo.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Sarah K. Johnson

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 69 Months 2 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 thereof _____ (Month) _____ (Day) _____ (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Nov 20-1940 (b) Loretta M. Leonard
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Sept day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that he/she was h_____ 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 _____

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 Eugene B. Munier (her) _____
Address Chadwick Date signed _____

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

SUPPLEMENTARY

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

