

FILED NOV 15 1940

Registration District No. 7

Primary Registration District No. 5164

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Nine Mile Prairie 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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Robert T. Lee Johnson *Colored*

3. (b) If veteran, name war Dont Know 3. (c) Social Security No. None

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased 1916 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min. about 94

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Don't know

13. Birthplace Don't know (City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature May Robinson

(b) Address Don't know

17. (a) Burial (b) Date thereof Oct 23-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson Graveyard Northwest Williamsburg

18. (a) Signature of funeral director By colored friends

(b) Address By order of coroner

19. (a) Oct 23, 1940 (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway
(c) City or town Nine Mile Prairie Township
(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 Oct. day 22^d year 1940 hour _____ minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him *in deep* alive on Oct 23^d - 11 a.m., 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Natural causes from old age

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 A. W. Holman, coroner (or other) _____
Address 8-E-8E St. Fulton, Mo. Date signed _____

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

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

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.

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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.