

Registration District No.

316

Primary Registration District No.

2001

Registrar's No.

797-A

1. PLACE OF DEATH:

(a) County GREENE
Springfield
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burge Hospital
(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

Johnson, Charles W. William

3. (b) If veteran, name war

no

3. (c) Social Security No.

None

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased Sept 23 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 6 hr. min.

9. Birthplace Lackwood, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Inf.11. Industry or business Inf.12. Name Charles Edward Hactrey Johnson13. Birthplace Unknown, Mo.
(City, town, or county) (State or foreign country)14. Maiden name Hildrich Huff15. Birthplace Unknown, Mo.
(City, town, or county) (State or foreign country)16. (a) Informant Fred L. Johnson(b) Address Lackwood, Mo.17. (a) Removed (b) Date thereof Sept 29 '40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Lackwood, Mo.18. (a) Signature of funeral director J. L. Haunschild(b) Address Lackwood, Mo.19. (a) Sept 24, 1940 (b) Ralph Brooks
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town Lackwood
(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 9 day 29
year 1940 hour 9 minute 17 M.

21. I hereby certify that I attended the deceased from 9-26-40
_____, 19____, to 9-29-40, 19____;
that I last saw him alive on 9-28-, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Pail injury

Due to _____

Due to 157 1/2Other conditions Prematurity
(Include pregnancy within 3 months of death)Major findings Spina Bifida
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?
Y/NWhile at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature Urban Busch (M. D. or other) _____Address Springfield Date signed 9-29-40

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35290**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **797A**

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

1. PLACE OF DEATH:

(a) County **Oregon**
(b) City or town **Springfield**
(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

Charles Wm Johnson

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **s**

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased.

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

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.....

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) **10/24/40**

(Date recorded local registrar)

(b) **W. E. Handley, M.D.**

(Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **29**
year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

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 **Urban Buser** (M. D. or other).....

Address **Springfield**.....

SUPPLEMENTAL COPY

