

Registration District **200318** Primary Registration District No. **2001**

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

1. PLACE OF DEATH: **Greenfield**
(a) City or town **Greenfield**
(If outside city or town limits, write "RURAL" and name of township)
(b) Name of hospital or institution: **840 - W. Scott St**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **4 weeks** _____
years, months or days _____

3. (a) PRINT FULL NAME **William V. Johnson**
3. (b) If veteran, name war **SS 499-14-5105**
3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Mattie Johnson**
6. (c) Age of husband or wife if alive **61** years
7. Birth date of deceased **Feb. 16 - 1873**
(Month) (Day) (Year)

8. AGE: Years **67** Months **9** Days **0**
If less than one day _____ hr. _____ min.

9. Birthplace **Fort Scott Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Business**

11. Industry or business **Antiquities**

12. Name **W. B. Johnson**

13. Birthplace **Unknown Georgia**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Dean**

15. Birthplace **Unknown Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mattie Johnson**
(b) Address **Buffalo Mo**

17. (a) **Removal** (b) Date thereof **11-18-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Buffalo Mo**
18. (a) Signature of funeral director **F. B. Jones**
(b) Address **Buffalo Mo**

19. (a) **11-18-40** (b) **W. E. Hurdley MD**
(Date received local registrar) (Registrar's signature) Address **Conway Greene County** Date signed **11-15-40**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Dallas**
(c) City or town **Buffalo**
(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 **Nov** day **16**
year **1940** hour **about 5** minute _____ A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him **in bed** alive on **Nov 16**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cowman Schistos**
Anterior-Subacute Carditis -
thrombotic disease
Duration **Immediately**
Death

Due to _____
Due to _____

Other conditions **Shunt** **9-5-19**
(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? **Y**
1941 (Specify type of place) _____
While at work? _____ (e) Means of injury _____
Signature **R. M. White** (M. D. or other) **Y**
Address **Conway Greene County** Date signed **11-15-40**

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 J. B. Jones
Licensed Embalmer No. 2508
P. O. Address Buffalo, N.Y.

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.