

No. 2  
4-13-40  
5-17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Dr. Langston  
38749  
State File No.  
Registrar's No. 959

Registration District No. 318

Primary Registration District No. 2001

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

1. PLACE OF DEATH:  
(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution City Hosp.  
(d) Length of stay: In hospital or institution 9 Hours  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jesse M. Johnson  
(b) If veteran: name war no  
(c) Social Security No. 491-03-1342

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife May Johnson 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased August 25 1887  
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Dispatcher

11. Industry or business Yellow Cab. Co.

12. Name James Johnson

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

14. Maiden name Sarah Virgin

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

16. (a) Informant Mrs. Sarah Johnson  
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Dec. 3 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn  
(d) Signature of funeral director H. H. Lohmeyer  
(e) Address Springfield, Mo.

19. (a) 12-3-40 (b) W. E. Haudley M.D.  
(Date received local registrar) (Registrar's signature)  
R. Y. B. (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(d) Street No. 593 W. Pine  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30 year 1940 hour 12 minute 20 a. M.  
21. I hereby certify that I attended the deceased from Nov. 28, 1940, to Nov. 30, 1940  
that I last saw him alive on Nov. 29 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction  
mechanical  
Due to Malignancy of prostate  
with metastases

Other conditions (Include pregnancy within 3 months of death) 51

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes  
While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
Signature W. Roland Langston (M. D. or other) W. D.  
Date signed 2/3/40

Duration

about 4-5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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, fact should be so stated above.**

*[Handwritten mark]*