

No. 2
1-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39953

Registration District No. 830 Primary Registration District No. 6101 Registrar's No. _____

DEC 11 1940

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Rural
(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 _____
In this community _____
years, months or days ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County County
(c) City or town Rural Essex
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME Jonnie Johnson
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 17 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 4 hr. _____ min.

9. Birthplace Stoddard Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business 1

MOTHER FATHER { 12. Name Johnnie Johnson
13. Birthplace Mississippi
14. Maiden name Vera Lee Johnson
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Johnnie Johnson
(b) Address Essex, Mo. R.#1

17. (a) Burial (b) Date thereof 9 22 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Broadwater Blankenship-Strickland
18. (a) Signature of funeral director Dexter, Mo.
(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21
year 1940 hour 2 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 21
1940 to Sept 21, 1940
that I last saw him alive on Sept 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition / Pneumonia

Duration 3 weeks

Due to _____

Due to _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 Dr. J. J. ... (M. D. or other) _____
Address Morehouse mo Date signed 9/22/40

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

158

RECEIVED

District Health Officer No. 2

District File Number 1240-1783

Date Filed 12/9/40

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State-File No. 3996-3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 6101

Registrar's No.

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

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Richland T.P.
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Lonnie Johnson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race B

6. (a) Single, widowed, married, divorced S

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 1 Months 1 Days 4 If less than one day _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____

(Date received local registrar) (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 21
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 9
21, 1940, to 9-21, 1940
that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death malnutrition

Pneumonia Labor

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 Am. Johnson (M. D. or other) _____

Address Morsehouse, Mo. Date signed 10/1

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39953
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 839

Primary Registration District No. 610.1

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

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Richland T.P.
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lonnie Johnson

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

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

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 Months Days If less than one day min.
1 1 4 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-13-41 (b) J.P. Brandon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Stoddard
(c) City or town Essex, Mo. R.R.
(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 Sept day 21
year _____ 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 _____

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 J.M. Sarno (M. D. or other) _____

Address Warehouse Date signed _____

SUPPLEMENTARY

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