

Registration District No. **875**

Primary Registration District No. **6162**

Registrar's No. **283**

FILED DEC 11 1940

108

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Bural, Washington Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp # 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2yr 5mo 21 day
(Specify whether years, months or days) 5

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis
(c) City or town Plato
(If outside city or town limits, write "RURAL")
(d) Street No. none
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

3. (a) PRINT FULL NAME Albert M Johnson

3. (b) If veteran, name war unknown 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased Aug 16, 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 22 If less than one day hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Heran Johnson

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

14. Maiden name Rosa G. Johnson

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

16. (a) Informant Taylor Elliott

(b) Address Calool Mo

17. (a) Bural (b) Date thereof 11/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calool Mo

18. (a) Signature of funeral director Marsh, Cheige

(b) Address Newada Mo

19. (a) 11-15-40 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 8
year 1940 9 hour 20 minute 45 M.

21. I hereby certify that I attended the deceased from 1-25-1939
11-8-1940 to 11-8-1940

that I last saw him alive on 11-7-1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocardites

Due to _____
Due to 4 of C

Other conditions Chronic Otitis Media (left)
(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? 795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. J. Boyd (M. D. or other) MD
Address State Hosp #3 Date signed 11/8/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SEP 13 1948

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1692

Date Filed 12-4-40

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

Mark Eichinger

Licensed Embalmer No.

2656

P. O. Address

Nebraska, Mo

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.