

S. No. 2  
4-73-40  
I X2313

**MAR 14 1941**

Registration District No. **241**

Primary Registration District No. **5354**

Registrar's No. **1272**

**1. PLACE OF DEATH:**

(a) County **Dallas**  
(b) City or town **Rural Benton Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**BUFFALO Mo**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **78 years** (Specify whether  
years, months or days)

3. (a) PRINTED FULL NAME: **Charles F 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 **W I**

6. (b) Name of husband or wife **Rebecca P Johnson** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: **18** (Month) **4** (Day) **1844** (Year)

8. AGE: Years **96** Months **3** Days **21** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Stockholm Sweden** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Unknown**

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 **Anna Cause**

(b) Address **BUFFALO MO**

17. (a) **BURIAL** (b) Date thereof **2-27-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Lawn**

18. (a) Signature of funeral director **L B Jones**

(b) Address **Buffalo Mo**

19. (a) **3-10-40** (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MO** (b) County **Dallas 30**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No **BUFFALO Mo**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **2** day **25**  
year **1941** hour **12** minutes **30** M.

21. I hereby certify that I attended the deceased from **2-10** 1941 to **2-25** 1941;  
that I last saw him alive on **2-25** 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
**Chronic myocarditis and Myocardial degeneration (7)**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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? **210**

(e) Means of injury \_\_\_\_\_ (Specify type of place)

23. Signature **R.E. Hanel** (M. D. or other) **PHO**

Address **Buffalo** Date signed **2-6-41**

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

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RECEIVED

District Health Officer No. 7;

District File Number 3-41-524

Date Filed 3-12-41

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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

*Clyde Montgomery*

Licensed Embalmer No. 35-92

P. O. Address Buffalo 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, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6790

Registration District No. 241

Primary Registration District No. 58574

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Dallas  
(b) City or town Benton 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.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME

Chas. F. 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 w  
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  
96 3 21 hr. 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) Harvey Moore (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 2 day 25 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... 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 P. E. Hannell (M. D. or other)

Address Buffalo Mo Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

