

APR 28 1941 **477**

Registration District No. **477**

Primary Registration District No. **4290**

Registrar's No. **25**

1. PLACE OF DEATH:

(a) County **LEWIS**
(b) City or town **LEWISTOWN**
(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 **1** (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **LESLIE Monnell JOHNSON**

3. (b) If veteran, name war **Worlds WAR 1912** 3. (c) Social Security No. **490-18-7127**

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **SUSIE Lovilets JOHNSON** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **APRILE 23, 1894**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	46	10	21	_____ hr. _____ min.

9. Birthplace **Durham MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **Horticulturist**

11. Industry or business **Plants and Tree Doctor**

12. Name **Benjamin F. Johnson**

13. Birthplace **Durham MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Lilya C. Bross**

15. Birthplace **Auncney MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Susie M. Johnson**

(b) Address **Lewistown, MO**

17. (a) **Burial** (b) Date thereof **3 16 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lewistown, MO**

18. (a) Signature of funeral director **James A. Cader**

(b) Address **Lewistown MO**

19. (a) **3/17/41** (b) **P. W. Jennings, M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **LEWIS**
(c) City or town **LEWISTOWN**
(If outside city or town limits, write "RURAL")
(d) Street No. **0** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14**
year **1941** hour **2** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **March 14, 1941** to **March 14, 1941**
that I last saw him alive on **March 14, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute indigestion** Duration **10 hrs.**

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? _____

(Specify type of place) **While at work?** (e) Means of injury **?**

23. Signature **Harry L. H. Groder, D.O.**

Address **Lewistown, MO** Date signed **Mar. 15**

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

56006

1182

FEB 10 1945

FEB 8 1945

RECEIVED

District Health Officer No. 10

District File Number 4-41-684

Date Filed APR 10 1941 APR 10 1941

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 myself

....., Registered Apprentice No.

working under my personal supervision.

Signed James A. Cades
Licensed Embalmer No. 2532

P. O. Address Livestown 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11217

Registration District No. 477

Primary Registration District No. 4290

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Leicester
(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 Leslie Morrell 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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years _____ months _____ days
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years Months Days If less than one day
46 10 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) _____ (b) Date thereof _____ (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month Mar day 14
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to acute indigestion I do not know about the cause but the excessive formation of gas in stomach and intestines caused pressure upon the heart.
Due to _____
Other conditions (include pregnancy within 6 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration

6 hrs

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? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature F. W. Proctor (M. D. or other) Do.

Address Leicester Mo. Date signed Mar 19

SUPPLEMENTAL

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

1941

S-11217