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U. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16039

Registration District No. 824 Primary Registration District No. 6076 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Shannon
(b) City or town: Rural Eunice Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Shannon
(c) City or town: Rural
(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.

3. (a) PRINT FULL NAME: James M. Johnson
3. (b) If veteran, name war: X
3. (c) Social Security No.: X
4. Sex: M
5. Color or race: N
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: 68 years
7. Birth date of deceased: Mar (Month) 23 (Day) 1867 (Year)
8. AGE: Years 73 Months 11 Days 14 If less than one day hr. min.
9. Birthplace: Johnson Co (City, town, or county) Ill (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: Lumber
12. Name of father: Jacob Johnson
13. Birthplace of father: Unknown (City, town, or county) (State or foreign country)
14. Maiden name of mother: Mary [illegible]
15. Birthplace of mother: Ill (City, town, or county) (State or foreign country)
16. (a) Informant: Sam Johnson
(b) Address: Eunice Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 13-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Mennill Chapel
18. (a) Signature of funeral director: [illegible]
(b) Address:
19. (a) 3-12-41 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 12 - 1941 year hour 8 - minute 40 a.m.
21. I hereby certify that I attended the deceased from Feb Feb 10, 1941, to Mar 12, 1941; that I last saw him alive on Mar - 11 - 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia Coma	
Due to: Cancer of Prostate	
Due to: 51 P	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

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? 744
While at work? (Specify type of place) (e) Means of injury:
23. Signature: Frank Hyde (M. D. or other) D
Address: Eunice Mo Date signed:

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 541/662
Date Filed _____

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.