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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22122

Registration District No. 527 Primary Registration District No. 4313 Registrar's No.

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon
(c) City or town Bevier
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EMMETT JOHNSON
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓
4. Sex Male 5. Color or race White 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 APRIL 23 - 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 10
year 1941 hour 7 minute 40 P.M.
21. I hereby certify that I attended the deceased from 2-14-1941
to 7-10-1941
that I last saw him alive on 7-1 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 2 17 hr. min.

Immediate cause of death
Acute nephritis Duration 4 days
Acute influenza
(Respiratory) approx. 5 mo
Due to _____
Due to _____

9. Birthplace Bevier Mo
(City, town, or county) (State or foreign country)
10. Usual occupation RETIRED COAL MINER
11. Industry or business _____

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.

MOTHER FATHER {
12. Name WALKER JOHNSON
13. Birthplace Macon Mo
(City, town, or county) (State or foreign country)
14. Maiden name MARTHA BUCHANAN
15. Birthplace HANNIBAL Mo
(City, town, or county) (State or foreign country)

16. (a) Informant A.L. ADAMS
(b) Address Bevier Mo
17. (a) BURIAL (b) Date thereof 7-12-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation WEST OAKWOOD
18. (a) Signature of funeral director H.T. Edwards
(b) Address Bevier Mo
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 H. P. Honnaway (M. D. or other) _____
Address Macon Mo Date signed 7-17-41

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

JUL 19 1947

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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 *M. E. Edwards*

Licensed Embalmer No. *1961*

P. O. Address *Beverly Hills*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 527

Primary Registration District No. 4313

Registrar's No. _____

1. PLACE OF DEATH:

(a) County macon

(b) City or town _____
(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 Emmett Johnson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year _____ month _____ day _____

7. Birth date of deceased Apr. 23 1879
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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) Aug 20 - 1941 Edw. Simpson
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1941 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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

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

