

Registration District No. **744**

Primary Registration District No. **3035**

Registrar's No. **68**

1. PLACE OF DEATH:

(a) County **Ray**
 (b) City or town **Richmond**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community **all life**
years, months or days)

3. (a) PRINT FULL NAME **HELEN LOUISE JOHNSON**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

6. (b) Name of husband or wife **Walter Johnson** 6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **November 21, 1913**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	27	7	20	hr. min.

9. Birthplace **Richmond, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Duties**

11. Industry or business.....

12. Name **W. L. Williams**

13. Birthplace **Richmond, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Nellie May Hedrick**

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

16. (a) Informant **Walter Johnson**

(b) Address **Richmond, Mo.**

17. (a) **Burial** (b) Date thereof **July 13, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Richmond, Mo.**

18. (a) Signature of funeral director **W. L. Williams**

(b) Address **Richmond, Mo.**

19. (a) **July 13-41** (b) **Malcolm Jackson**
(If received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ray**
 (c) City or town **Richmond**
(If outside city or town limits, write "RURAL")
 (d) Street No. **321 Wellington St.**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **11th**
 year **1941** hour **10** minute **15** a. m.

21. I hereby certify that I attended the deceased from **June 24**
 19**41** to **July 11** 19**41**;
 that I last saw **her** alive on **July 11**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **T.B.**

Duration

Due to.....

Due to.....

Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations.....

Of autopsy.....

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **L. D. Green** (M. D. or other).....

Address **Richmond, Mo.** Date signed **7-13-41**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-26-41

AUG 21 1948

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, ~~OKK~~ _____,
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed *E. H. ...*

Licensed Embalmer No. 2073

P. O. Address Richmond, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29180

Registration District No. 744

Primary Registration District No. 3035

Registrar's No.

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond
(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 years, months or days)

3. (a) PRINT FULL NAME Helen L. Johnson

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex F 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

7. Birth date of deceased Nov 21 1912
(Month) (Day) (Year)

8. AGE: Years 27 Months 3 Days 10 If less than one day 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
(Burial, cremation, or removal) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1941 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from July 13 1941 to July 13 1941, 19...
that I or saw him/her alive on July 13 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular J.B.
Cerebrovascular J.B.

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature J. D. Gorman (M. D. or other)

Address Richmond, Mo. Date signed

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

Richmond Mo.

SUPPLEMENTARY

