

No. 2
13-40
17-39
X23155

FILED SEP 11 1941

Registration District No. 836

Primary Registration District No. 6100

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

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Bernie, Rural - BR Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
(c) City or town Parma, Mo. 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25th
year 1941 hour 10:30 minute _____ P. 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 Strangulation
Duration _____

Due to Whooping Cough and Membraneous Croup.

Due to _____
Other conditions A
(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? _____

(Specify type of place) _____
While at work? _____ (b) Means of injury _____
23. Signature J. A. Childs (My D. another) _____
Address Bloomfield, Mo. Date signed 8-27-41

3. (a) PRINT FULL NAME Deloice Johnson

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 4, 1935
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>6</u>	<u>6</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Chas. Johnson

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

14. Maiden name Selena Sawyer

15. Birthplace Helena, Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Johnson

(b) Address Parma, Mo. Route

17. (a) Burial (b) Date thereof 8-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Broad Water cemetery

18. (a) Signature of funeral director Duncan Funeral Serv

(b) Address Bernie, Mo.

19. (a) Aug 30-41 (b) Laura Hopkins
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

103

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 941-1259

Date Filed 9/9/41

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..... Deceased was not Embalmed.

..... 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, fact should be so stated above.