2
-41
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X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 10 1948

Registration District No. 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3011

State File No. 31362

Registrar's No. 139

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community -- years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1321 Tracy 8
(If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Cornelious Johnson

3. (b) If veteran, name war Philippine Insurrection

3. (c) Social Security No. Yes-not remembered

4. Sex Male 2

5. Color or race Colored

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Lillie-deceased

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 5, 1876 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	9	19	hr. min.

9. Birthplace Pine Bluff, Arkansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Warehouseman

11. Industry or business ?

FATHER
12. Name Howard Johnson
13. Birthplace - South Carolina 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susie Johnson
15. Birthplace Macon Georgia 1
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records, Veterans Administration
(b) Address Excelsior Springs, Mo.

17. (a) Kansas City, Mo. (b) Date thereof 9-24-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Claude Prichard
(b) Address Claude Prichard
Excelsior Springs, Mo.

19. (a) 9-24-41 (Date received local registrar) (b) Mrs. Ola McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24th year 1941 hour 10:15 minute A. M.

21. I hereby certify that I attended the deceased from September 21, 1941, to September 24, 1941; that I last saw him alive on September 24, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypertension	
Cerebral Hemorrhage	
Due to Chronic Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

131b

Major findings: Of operations ~~No autopsy~~

Of autopsy No 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? (e) Means of injury

23. Signature E A Welch (M. D. or other)
E. A. WELCH, M.D.
Address Veterans Administration Date signed 9-24-41

(Licensed Embalmer's Statement on Reverse Side) Excelsior Springs, Mo.

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 10-9-41

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.