

No. 2
10-39
2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED OCT 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32758

Registration District No. 838

Primary Registration District No. 2098B

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter (Rural)
(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

8. (a) PRINT FULL NAME Donald Wayne 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 Sept. 15 1941
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	9	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Paul Johnson

13. Birthplace 6 Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lucille Harvey

15. Birthplace Kinder Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Johnson

(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 9/25/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Point Cem.

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Dexter, Mo.

19. (a) 10. 2. 1941 (b) Jennie Busted
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103

(c) City or town Dexter (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 Sept. day 24 th
year 1941 hour 5 minute 0 P.M.

21. I hereby certify that I attended the deceased from Sept. 23 1941 to Sept. 24 1941
that I last saw him alive on Sept 23 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Duration 3 day

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)

PHYSICIAN

Major findings: ✓

Of operations _____

Of autopsy no

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) no

(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)

(a) Means of injury ✓

23. Signature S. S. Laws (M. D. or other)

Address Dexter Mo. Date signed 9-24-41

RECEIVED

District Health Office No. 2,

District File Number 1041-192

Date Filed 10/13/41

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 838

Primary Registration District No. 6098B

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Wester Rural
(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 Donald W Johnson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 15, 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of 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 Sept day 14
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
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)
(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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Wester rural

