No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7216

Registration District No. 532 Primary Registration District No. 6242 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Richland Township
(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)
In this community 88

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Macon 61
(c) City or town Rural 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. —
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — 0 years.

3. (a) PRINT FULL NAME William H 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 Widowed
6. (b) Name of husband or wife Analyza Johnson
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased April (Month) 16 (Day) 1853 (Year)

8. AGE: Years 88 Months 10 Days 5 If less than one day ____ hr. ____ min.

9. Birthplace Macon Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER
12. Name James Johnson
13. Birthplace Ky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Ellyann Rafer
15. Birthplace Dent Knox (City, town, or county) (State or foreign country)
16. (a) Informant Watt Johnson
(b) Address La Plata Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 23, 42 (Month) (Day) (Year)
(c) Place: burial or cremation La Plata
18. (a) Signature of funeral director D S Christie
(b) Address La Plata
19. (a) Feb 23, 1942 (Date received local registrar) (b) Ola B Webber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day Feb year 1942 hour 8 minute 30 P.M.
21. I hereby certify that I attended the deceased from Feb 15, 1942, to Feb 21, 1942; that I last saw him alive on Feb 19, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	1
Due to Infirmities of old age	
Due to	
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.

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 Ralph W Tillet (M. D. or other) DO
Address La Plata Mo Date signed 2/23/42

1051 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-431
Date Filed MAR 12 1942

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 wit the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7216

Registration District No. 532 Primary Registration District No. 6242 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Mason

(b) City or town 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)

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

3. (a) PRINT FULL NAME William H. 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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased Apr (Month) 16 (Day) 1853 (Year)

8. AGE: Years 88 Months 10 Days 5 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
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Influenza	
Due to Infirmities of old age	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 107
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)
(b) 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 Ralph W. Gillet (M. D. or other) 100
Address La Plata Mo Date signed