U. S. No. 2
1—11-10-39
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 14 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24319
State File No.

Registration District No. 318 Primary Registration District No. 2001 Registrar's No. 561

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 da.
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Webster
(c) City or town Niangua 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.

3. (a) PRINT FULL NAME James Newton Johnston
3. (b) If veteran name war No
3. (c) Social Security No. Unknown
4. Sex Male
5. Color or race wht
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive X X years
7. Birth date of deceased Sept (Month) 11 (Day) 1892 (Year)

8. AGE: Years 49 Months 10 Days 18 If less than one day hr. min.
9. Birthplace Webster Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name Arch H Johnston
FATHER 13. Birthplace Webster Co (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name Amanda Casey
MOTHER 15. Birthplace Webster Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Miss Betty Johnston, Sister
(b) Address Niangua Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 29 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Unity Cemetery
18. (a) Signature of funeral director
(b) Address
19. (a) 7-29-42 (Date received local registrar) (b) B. M. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1942 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from July 20, 1942, 19..., to July 29, 1942, that I last saw him alive on July 29, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Emphysema of Rt Chest — Duration
Due to: Pneumonia — 6 weeks previous
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 W. A. Dell (M. D. or other)
Address Springfield Mo Date signed 7-29-42

(Licensed Embalmer's Statement on Reverse Side)

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. 3312

P. O. Address Marshfield 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, above space should be left blank.

S. No. 2B
M—8-21-41
1 X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24319

Registration District No. 318 Primary Registration District No. 2001 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist
(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 James Newton Johnston

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 (Month) 11 (Day) 1895 (Year)

8. AGE: Years 49 Months 10 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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)

MOTHER
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 July 29
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.

Immediate cause of death Empyema of Rt Chest

Due to Pneumonia 6 wks previous

Due to Bronchial

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107

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

23. Signature Wakefield (M. D. or other)
Address Date signed

Aug 26/42