S. No. 2
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3-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27293

FILED AUG 24 1942 384

Registration District No. 384 Primary Registration District No. 4227 Registrar's No. 56

1. PLACE OF DEATH:

(a) County: Howell

(b) City or town: West Plains mo town
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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 ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Howell

(c) City or town: West Plains
(If outside city or town limits, write "RURAL")

(d) Street No.: Rural
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) 1

If yes, name country ____

3. (a) PRINT FULL NAME: Jno Wesley 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: Electra E Johnson

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

7. Birth date of deceased: 4-16- (Month) (Day) (Year)

8. AGE: Years: 96 Months: ____ Days: ____ If less than one day ____ hr. ____ min.

9. Birthplace: Alabama (City, town, or county) 1 (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: work

FATHER
12. Name: "
13. Birthplace: " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: "
15. Birthplace: " (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Hugh Johnson

(b) Address: West Plains Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof: 5/5-42 (Month) (Day) (Year)

(c) Place: burial or cremation: Evergreen

18. (a) Signature of funeral director: Robertson

(b) Address: West Plains mo

19. (a) 1/20-42 (Date received local registrar) (b) Grace Hadley (Registrar's signature)

1125

(Licensed Embalmers Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 5 day: 1 year: 1942 hour: 11 minute: 00 P. M.

21. I hereby certify that I attended the deceased from April 1, 1942 to May 1, 1942 that I last saw him alive on April 15, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: disease of the heart ✓ — Duration

Due to ____

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? ____

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

23. Signature: B. D. Gunn (M. D. or other) M.D.

Address: West Plains Mo. Date signed: 5-14-42

Chem

RECEIVED
District Health Officer No. 5,
District File Number 842682-
Date Filed 8-21-42

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 Paige D Robertson

Licensed Embalmer No. 3435

P. O. Address West Plains, N

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

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

V. S. No. 2B
0M—8-21-41
I X29288

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27293

Registration District No. 384 Primary Registration District No. 4227 Registrar's No. 56

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(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 Jno. Wesley 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 April 16 1846
(Month) (Day) (Year)

8. AGE: Years 95 Months 8 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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) 5/20-42 (Date received local registrar) (b) Gail Harlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute 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 Failure of the heart

Due to Myocarditis (chronic)

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature D. Gunn (M. D. or other) MD

Address H-P Mo Date signed 5/19-42

SUPPLEMENTARY

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