

FILED SEP 14 1942
Registration District No. **297**

Primary Registration District No. **6020**

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

1. PLACE OF DEATH:
(a) County **Ray**
(b) City or town **Crooked River R.R. No 2**
(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 _____
In this community **74 1/2** years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME **LOUIS ELY JOHNSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **yes**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Sula M. Seibold** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **April - 13 - 1869**
(Month) (Day) (Year)

8. AGE: Years **63** Months **4** Days **13** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer + Carpenter**

11. Industry or business
12. Name **John W. Johnson**
13. Birthplace **St Louis Co Ill** (City, town, or county) (State or foreign country)
14. Maiden name **Cydia Ann Ely**
15. Birthplace **Ray Co Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Clifton Johnston**
(b) Address **Ray Mo**

17. (a) Burial (b) Date thereof **Aug 30 42**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **See Laurelock Cem**

18. (a) Signature of funeral director **Geo W. Knipschulte**
(b) Address **Hardin Mo**

19. (a) August 29 1942 (b) **Mrs. Chew Shopp**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **89**
(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 **August** day **27**
year **1942** hour **2** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Aug 23**, 1942, to **Aug 27**, 1942
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** **4 days**
Duration

Due to _____
Due to _____

Other conditions **Hypertension** **7 years**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations **9/4/42**
Of autopsy _____
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 **Dr. E. G. Renan** (M. D. or other) **ABDO**
Address **Richmond, Mo** Date signed **Aug 29, 42**

RECEIVED

District Health Office No. 8,

District File Number

Date Filed

2-11-42

4-11-42

MAY 31 1945

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 me

Registered Apprentice No.

working under my personal supervision.

Signed John W. Knipschild

Licensed Embalmer No. 3789

P. O. Address Hardin 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28001
Registrar's No. 19

Registration District No. 297

Primary Registration District No. 6020

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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 Louis Ely Johnson
(b) If veteran, name war..... 3 (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased: April 13 (Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days 13 (If less than one day hr. min.)

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

10. Usual occupation.....

11. Industry of 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)..... (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) Aug. 29-1942 (b) Mrs. Char. W. Heyland (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray
(c) City or town R.R. No. 2 (If outside city or town limits, write "RURAL.")
(d) Street No. R.R. No. 2 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... live on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

