

30239

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

S. 1
M.
v. 5-17-39-
I X29484

Registration District No. 101

Primary Registration District No. 5410

Registrar's No.

1. PLACE OF DEATH:

(a) County Douglas

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

(c) Name of hospital or institution: Rural
(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 Missouri (b) County Douglas

(c) City or town Siloam Springs
(If outside city or town limits, write "RURAL")

(d) Street No. Richland Township
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME James Thomas Johnson

(b) If veteran, name war.

(c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1942 hour 4⁰⁰ minute P M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Johnson

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased March 8 1868
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-26-1942 to 9-29-1942
that I last saw him alive on 9-26-1942
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>6</u>	<u>21</u> hr. min.

Immediate cause of death Hypertensive Myocarditis

Due to Arteriosclerosis

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

Due to Senility

Other conditions (include pregnancy within 3 months of death) 9/28

10. Usual occupation Farmer

Major findings: 9/28

Of operations.

Of autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business.

12. Name Granville Johnson

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

14. Maiden name.

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

16. (a) Informant Julian Johnson

(b) Address Siloam Springs, Mo.

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?

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

(c) Place: burial or cremation

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

23. Signature E. B. Bohrer (M. D. or other) MD

Address West Plains, Mo. Date signed 9-30-42

18. (a) Signature of funeral director Johnson

(b) Address Siloam Springs Mo.

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

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

34
00

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30239

Registration District No. 101

Primary Registration District No. 5410

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Douglas
(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

3. (a) PRINT FULL NAME James J. Johnson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color w 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 ma (Month) 8 (Day) 19 (Year)

8. AGE: Years 74 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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) Oct 1 1943 (b) Mrs. J. K. Spence
(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 _____ day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive 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

MOTHER FATHER

1942
30239
SUPPLEMENTARY