

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42270**

FILED JAN - 7 1942
Registration District No. **366**

Primary Registration District No. **6244**

Registrar's No. **67**

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Buffalo, Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 64 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Prof R 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 Married
6. (b) Name of husband or wife Sarah Johnson 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Dec 22 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days 27 If less than one day hr. min.

9. Birthplace Washington Mo. U.S.A.
(City, town, or county) (State or foreign country)

10. Usual occupation Ministry

11. Industry or business
MOTHER FATHER { 12. Name General R Johnson
13. Birthplace Gen Searcy
(City, town, or county) (State or foreign country)
14. Maiden name Joseph Hayes
15. Birthplace Washington Mo. U.S.A.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Johnson
(b) Address Buffalo Mo

17. (a) Burial (b) Date thereof Nov 21 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo

18. (a) Signature of funeral director J P Ingels
(b) Address Polaris Mo

19. (a) 12-15-1942 (b) Joseph L. Thurman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Washington
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. Tiff, Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A. 8 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19
year 1942 hour 11:30 minute 9 A.M.

21. I hereby certify that I attended the deceased from Oct 19, 1942 to Nov 18, 1942
that I last saw him alive on Nov 18, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 5 days

Due to Hypertension

Due to Fracture cervical spine 1 yr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 110

(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 J P Ingels (M.D. or other) do
Address 222 Soto, Mo Date signed 11-21-42

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X19511

strict Health Officer No. 4
District File Number 149-15-6
Date Filed 1-6-43

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, above space should be left blank.

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State File No. 42270
Registrar's No. 67

Registration District No. 366

Primary Registration District No. 6244

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

1. PLACE OF DEATH

(a) County Washington
(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 S. R. 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 _____

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

7. Birth date of deceased Dec 22 (Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days mo. 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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 20 Day 19 Year 1942 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 Cerebral hemorrhage Duration 5 days

Due to Supertension with fracture cervical spine

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) Accident

(b) Date of occurrence Oct, 1941

(c) Where did injury occur? Tiff (City or town) Washington (County) MO (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at Tiff mines

While at work? yes (Specify type of place) (e) Means of injury fallen on rock

23. Signature J. P. Dugan (M. D. or other) MD

Address De Soto, Mo Date signed 2-24-43

SUPPLEMENTARY

