

Registration District No. 38 Primary Registration District No. 3006-5+20 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: Noyes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day  
(Specify whether In this community 22 Days years, months or days)

3. (a) PRINT FULL NAME THOMAS JOSEPH JOHNSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 1 - 5 - 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

22 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name John Johnson

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

14. Maiden name Maxine Klott

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

16. (a) Informant Mrs. O.W. Holt

(b) Address 1608 Hinkson Ave., Columbia, Mo.

17. (a) Burial (b) Date thereof 1-28-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parker F. Searce

(b) Address Columbia, Mo.

19. (a) 1-28-43 (b) Edna H. Barber  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 10

(a) State Missouri (b) County Boone

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

(d) Street No. 1608 Hinkson  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27  
year 1943 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from over 1 - 27 - 1943 to 1 - 27 - 1943  
that I last saw h. alive on 1 - 27 - 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia  Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy no

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) No

(b) Date of occurrence

(c) Where did injury occur? No  
(City or town) (County) (State)

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

While at work? No (Specify type of place) (e) Means of injury □

23. Signature W. P. Searce (M. D. or other) MD

Address Columbia, Mo Date signed 1-28-43

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

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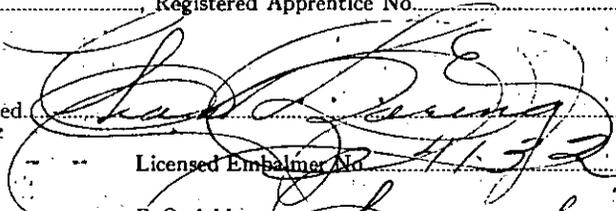
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**STATEMENT BY LICENSED EMBALMER**

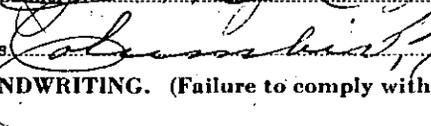
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed  .....

Licensed Embalmer No. 4132 .....

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. 1523  
Registrar's No. 18

Registration District No. 38

Primary Registration District No. 2006

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

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Thomas J. 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 S

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Boone Co. Mo. (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 Jan year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I or some one else on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Branchial neurinoma

Due to Did not see this baby till a hour two hrs before death. Family thought it only had a cold until began having convulsions.

Due to Was not conscious after

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Convulsions by ass.

Of operations \_\_\_\_\_

Of autopsy 107

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? \_\_\_\_\_

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

23. Signature W. P. Dyson (M.D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is arranged in several paragraphs across the page, but the characters are too light to be transcribed accurately.]