

No. 2
1-10-39
-17-39
X21492

3032

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 9 1943

Registration District No. 9-1343-267

Primary Registration District No. 594-5900

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Pemiscot

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

(c) Name of hospital or institution: Boonville Hospital
(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) _____ (Specify whether _____)

In this community _____ (Specify whether _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin 35

(c) City or town Deering (Rural) 0
(If outside city or town limit, write "RUHAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME LILLIAN JOYCE JOHNSON

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

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

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
			hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1942 hour 11:00 minute _____ a. M.

21. I hereby certify that I attended the deceased from Nov. 28 1942 to Nov. 29 1942
that I last saw h. ea alive on Nov. 29 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria

Duration 8 days

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 10

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Levi Johnson

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

14. Maiden name Zeffie Davis

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

16. (a) Informant Levi Johnson
(b) Address Deering Mo.

17. (a) Burial (b) Date thereof Nov 30-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mooreville - Miss

18. (a) Signature of funeral director Lentz Service
(b) Address Kennett Mo.

PHYSICIAN

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:

(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 _____

Signature Geo. M. Kelley (M. D. or other) RD

Address Deering, Mo. Date signed 11-29-42

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

2011-26-1943 George K. Richards

1-19-43

7/1
2-8
MSX 1

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3032
Registrar's No. 1

Registration District No. 267

Primary Registration District No. 5900

1. PLACE OF DEATH:

(a) County..... Pemissist
(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.....
In this community..... (Specify whether
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 Lillian Joyce Johnson
(b) If veteran, name war..... (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1942 hour 10 minute 9 M.
21. I hereby certify that I attended the deceased from 1942 to 1942,
that I last saw him live on June 14, 1942,
and that death occurred on the date and hour stated above.
Immediate cause of death.....

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced..... single
(b) Name of husband or wife..... none 6. (c) Age of husband or wife if alive..... none years
7. Birth date of deceased: June 14 (Month) 1942 (Day) 1942 (Year)

8. AGE: Years 2 Months 5 Days 15 If less than one day..... min.

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

10. Usual occupation..... none
11. Industry or business..... none

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) (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) (Date received local registrar)..... (b) George Lindhardt (Registrar's signature)

Due to.....
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)
(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..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

