

Dr. Davis

State File No. 11741

FILED APR 14 1943

Registration District No. 360

Primary Registration District No. 6224 611

Registrar's No. 421

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

1. PLACE OF DEATH:

(a) County Vernon Mo.
(b) City or town _____
(c) Name of hospital or institution: 3
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME Thomas Joseph Johnston

3. (b) If veteran, name war no 8. (d) Social Security No. none

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Maudie Johnston
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased April 16 1885
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 15
If less than one day _____ hr. _____ min.

9. Birthplace Vernon County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Thomas C Johnston
13. Birthplace Coal County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lillian Ellen Forester
15. Birthplace Delaware
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Maudie Taft

(b) Address Nevada Mo.

17. (a) Burial (b) Date thereof 3-6-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellflower Cemetery

18. (a) Signature of funeral director Allen W. Bays

(b) Address Nevada Mo.

19. (a) 3-8-43 (b) Hazel B. Bevers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 9th
year 1943 hour 7:30 minute _____ M.

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

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Broken neck
Crushing injury to
Due to chest

Due to _____

Other conditions 1706-6
(Include pregnancy within 3 months of death) 7th

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 in car

(b) Date of occurrence 3-9-43

(c) Where did injury occur? Nevada Vernon Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? U S 71

While at work? _____ (Specify type of place)
(e) Means of injury Automobile

23. Signature Brooklyn Davis (M. D. or other) Accid.

Address Nevada Date signed 3-5-43

RECEIVED

District Health Officer No. 7,

District File Number 3-43-36

Date Filed 4-6-43

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 H. H. Warmaduke

Licensed Embalmer No. 2070

P. O. Address Wanda

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.

Registration District No. 3 60

Primary Registration District No. 60224

Registrar's No.

1. PLACE OF DEATH:

(a) County Vienna
(b) City or town Rural - Washington W
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Killed on Hwy 71 - near Marmaton River
(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

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 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 m

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

7. Birth date of deceased April 16 1895
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 5 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Hazel B. Bewick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Year 1943 hour _____ minute _____ M.

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

that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

S-11741