

REG. MAY 8 1943 15  
Registration District No. ....

Primary Registration District No. 5300

Registrar's No. 29

1. PLACE OF DEATH:

(a) County CLINTON

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

(c) Name of hospital or institution:  
1  
(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 Missouri (b) County Clinton 25

(c) City or town Rural 0  
(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..... 0

3. (a) PRINT FULL NAME MYRNA FAY JOHNSON

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

4. Sex female 5. Color or race w 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 Jan 30 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 24 hr. min.

9. Birthplace St. Joseph Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Melvin Frank Johnson

13. Birthplace St. Joseph Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Beatty L. Ross

15. Birthplace St. Joseph Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Melvin Frank Johnson

(b) Address Osborn - Mo.

17. (a) Burial (b) Date thereof 4-24-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Benin Mo.

18. (a) Signature of funeral director O'Brien - Lyon

(b) Address Platteburg Mo.

19. (a) Apr 24-43 (b) Mrs Kathleen Harris  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day April  
1943 year 12 30 hour minute PM M.

21. I hereby certify that I attended the deceased from April 17  
1943, to Apr 24, 1943  
that I last saw him alive on Apr 17, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia ✓

Duration 2 1/2 days

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 G O Greeland (M. D. or other)  
Address Benin Mo. Date signed 4/24/43

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

**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.....

*Danell W. Lyon*

Licensed Embalmer No.....

*3640*

P. O. Address.....

*Plattsburg, Mo.*

**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. 14070

Registration District No. 75

Primary Registration District No. 5300

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Clinton

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton

(c) City or town Rural  
(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 Myrona F Johnson

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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

7. Birth date of deceased Jan 30 - 1943  
(Month) (Day) (Year)

8. AGE: Years 0 Months 2 Days 19 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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

20. DATE OF DEATH: Month Apr Day 24 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 d

Due to No complications

Due to \_\_\_\_\_

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

Major findings: Of operations 108

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? \_\_\_\_\_

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

23. Signature A O Givens (M. D. or other) \_\_\_\_\_

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

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

SUPPLEMENTARY

MOTHER FATHER

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

