

No. 2
2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36000**

Registration District No. **348**

Primary Registration District No. **4510**

Registrar's No. **26**

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Osgood Mo
(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 -)
years, months or days

In this community -
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan

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

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

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

3. (a) PRINT FULL NAME John C 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 Mary Johnson 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased July 19-1860
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>7</u>	<u>24</u>	<u>-</u> hr. <u>-</u> min.

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

10. Usual occupation Retired Farmer

11. Industry or business -

MOTHER FATHER { 12. Name Elijah Johnson

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

14. Maiden name Margaret Babb

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

16. (a) Informant Mrs Jno C Johnson

(b) Address Osgood Mo

17. (a) Burial (b) Date thereof 10-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson town, (M Jim)

18. (a) Signature of funeral director W. B. Brown

(b) Address Galt Mo

19. (a) Oct 25-1943 (b) Mrs John Todd
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13
year 1943 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 1943 to Oct 13 1943
that I last saw him alive on Oct 13 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to -
Due to -

Other conditions Refractive Chorea
(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)

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

While at work? - (Specify type of place) (c) Means of injury -

23. Signature U. S. Bradley (M. D. or other) -
Address Harper Mo Date signed Oct 14-43

1353

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 10

District File Number 11-43-1824

Date Filed ~~11-13-1943~~
NOV 13 1943

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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.