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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 11 1944
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1073

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town SPRINGFIELD MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2211 TAYLOR
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County GREENE
(c) City or town SPRINGFIELD MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 2211 Taylor
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SAMUEL CRAIG JOHNSON

MEDICAL CERTIFICATION

3. (b) If veteran, name war NONE 3. (c) Social Security No. unk

20. DATE OF DEATH: Month DEC day 27
year 1943 hour 2 minute 30 P. M.

4. Sex MALE 5. Color or face WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ELIZABETH JOHNSON 6. (c) Age of husband or wife if alive unk years
7. Birth date of deceased April 24 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-1-43, 19____, to 12-27-, 1943
that I last saw him alive on 12-27-, 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>80</u>	<u>8</u>	<u>3</u>	hr. _____ min. _____

Immediate cause of death De Compensating heart disease
Duration 6 mo

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

Due to _____
Due to _____

10. Usual occupation Janitor

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

11. Industry or business School System

Major findings: 95C2
Of operations _____
Of autopsy _____

12. Name S. C. Johnson

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

14. Maiden name May Ewing

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

16. (a) Informant Elizabeth Johnson
(b) Address SPRINGFIELD MO.

17. (a) Burial (b) Date thereof 12-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cem.
18. (a) Signature of funeral director W. K. Hughes & Co.
(b) Address SPRINGFIELD MO.
19. (a) 12-29-43 (b) Dr. M. Handley
(Date received local registry) (Registrar's signature)

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 C. E. Fuller (M. D. or other) _____
Address Springfield Mo Date signed 12/29/43

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.....

Ogden Slone Jr.

Licensed Embalmer No.....

4776

P. O. Address.....

Springfield

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.