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5-17-30
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43529

State File No.

DEC 20 1943 249
Registration District No.

Primary Registration District No. 6026

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds

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

(c) Name of hospital or institution: 1 mile North of Centerville
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Johnson

3. (b) If veteran, name war no

3. (c) 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 Emma Johnson

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Nov 3 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 0 If less than one day hr. min.

9. Birthplace Reynolds Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation farmer (retired)

MOTHER FATHER

11. Industry or business

12. Name Maudith Johnson

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

14. Maiden name Elizabeth Bayton

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

16. (a) Informant Elmer Johnson

(b) Address Centerville Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-4-43
(Month) (Day) (Year)

(c) Place: burial or cremation Centerville Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds

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

(d) Street No. 1 mile North of Centerville
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2 year 1943 hour 3 9M minute M.

21. I hereby certify that I attended the deceased from Sept 1 1943 to Dec 2 1943

that I last saw him alive on Dec 1 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cornary thrombosis of heart Duration

Due to Rheumatism

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 94a

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 J.R. Apple (M. D. or other)
Address Centerville Date signed Dec 4 1943

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

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

1243721
12-17-43

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.....

Arnold White

Licensed Embalmer No.....

3012

P. O. Address.....

Swanton Mass

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 299

Primary Registration District No. 6026

Registrar's No. _____

1. PLACE OF DEATH

(a) County Reynolds

(b) City or town Rural Carroll Twp
(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 _____
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 James 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 _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Nov 3 1903
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

8. AGE: Years 71 Months 1 Days 3 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) Dec 2nd 1943 (b) Max Joseph McMilligan
(Date received local registrar) (Registrar's signature)

Duration _____

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)

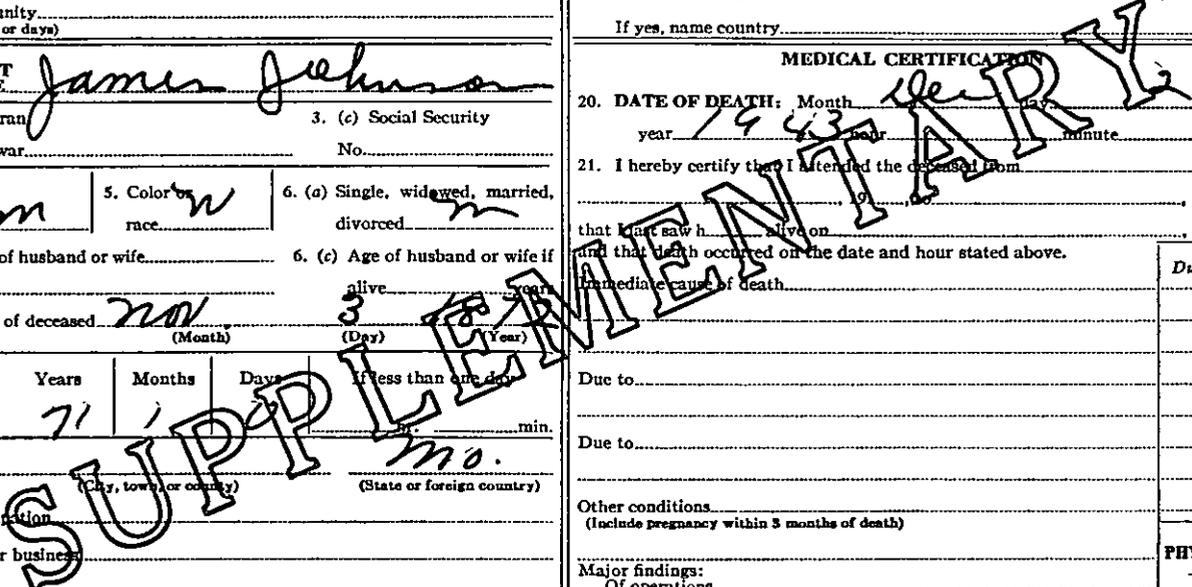
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



S-43529