

State File No. \_\_\_\_\_

Registrar's No. 27

FILED FEB 10 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. 3010

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

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Southeast Mo Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 hrs  
(Specify whether years, months or days)  
In this community 5 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 103  
(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

George Edward Johnson

(b) If veteran, name war \_\_\_\_\_

(d) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 18, year 1943, hour 12 minute 54 M.  
21. I hereby certify that I attended the deceased from 12-17-1943 to 12-18-1943; that I last saw him alive on 12-17-1943 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 17 1943  
(Month) (Day) (Year)

Immediate cause of death Measles  
Due to new born  
Due to \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 5 hr 2 min

9. Birthplace Cape Girardeau Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name George Johnson

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

14. Maiden name Wiley

15. Birthplace Cape Girardeau Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant George Johnson

(b) Address Adverse Missouri

17. (a) Burial (b) Date thereof Dec 18 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marqu Memorial Park

18. (a) Signature of funeral director George Johnson

(b) Address Adverse Missouri

19. (a) 1-22-44 (b) F. H. Phelps  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 160  
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 S

23. Signature D. B. Erwin (M. D. or other) \_\_\_\_\_  
Address Cape Girardeau Mo Date signed 1-21-44

1014

Recorder No. 4  
File Number 244-3401  
Date Filed 2-9-44

**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.....

not embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed Lloyd S. Morgan.....

Licensed Embalmer No. 3361.....

P. O. Address Advance, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 53Primary Registration District No. 2010Registrar's No. 27

## 1. PLACE OF DEATH:

(a) County Cape Girardeau  
 (b) City or town Cape Girardeau  
 (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)3. (a) PRINT  
FULL NAMEGeorge E. Johnson3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex M5. Color of  
race W6. (a) Single, widowed, married,  
divorced S

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if

7. Birth date of deceased

Dec 17 1943  
(Month) (Day) (Year)

\_\_\_\_\_

8. AGE:

Years

Months

Days

If less than one day

hr. min.

9. Birthplace

(City, town, or county)

mo.  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (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)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
 (c) City or town Advance  
 (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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1943 hour \_\_\_\_\_ 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 \_\_\_\_\_

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 sta-  
tistically.

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

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

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

MOTHER FATHER

SUPPLEMENTARY

FEB 11

FILE

2382