No. 2
—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1944

Registration District No. 1834

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

Dr. Haley

State File No. 11415

Registrar's No. 305

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 541 S Main
(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: 52 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Linn

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

(d) Street No.: 541 S Main
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: JAMES-WILLIAM-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: Married

6. (b) Name of husband or wife: Lillie M Johnson

6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: April (Month) 18 (Day) - 1866 (Year)

8. AGE: Years 77 | Months 10 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace: Hardin County (City, town, or county) Ohio (State or foreign country)

10. Usual occupation: Retired Grocer

11. Industry or business: .....

FATHER
12. Name: John W. Johnson
13. Birthplace: Hardin County (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name: Elizabeth Hill
15. Birthplace: Ohio (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Lillie Johnson
(b) Address: Brookfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar-15-1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Rose Hill Cemetery - Brookfield

18. (a) Signature of funeral director: Hill Chapel
(b) Address: Brookfield

19. (a) 3-15-1944 (Date received local registrar) (b) N H Cannon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 12 year 1944 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 16 1943 to Mar 12 1944 that I last saw h. alive on Mar 12 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Arteriosclerosis and Edema	1 yr
Due to: Arteriosclerosis General	?
Due to:	
Other conditions (Include pregnancy within 3 months of death): Pernicious Anemia	3 dy

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury: .....

23. Signature: Roy R. Haley (M. D. or other) MD
Address: Brookfield Mo. Date signed: 3-14-44

(Licensed Embalmer's Statement on Reverse Side)

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 J. W. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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.

S. No. 2B
M—5-43
Form I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 184 Primary Registration District No. 2038 Registrar's No. 305

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(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 .....

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 W. 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 .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Apr. (Month) 18 (Day) 1866 (Year)

8. AGE: Years 77 Months 10 Days ..... Unless than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Ohio (State or foreign country)
10. Usual occupation .....
11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day ..... year 1944 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h..... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to Bronchial Pneumonia (Pneumococcus)	
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 Roy R. Hale M. D. or other) MD
Address Brookfield Date signed 4/7/44

SUPPLEMENTARY

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FILED

11415