

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11867

FILED APR 13 1944

Registration District No. 270

Primary Registration District No. 6017

State File No. _____

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Camden Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none (Specify whether years, months or days)

In this community 73 yrs.

3. (a) PRINT FULL NAME Walford A. Johnson

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Never Married 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 30 th, 1867.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>		<u>33</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Johnson

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

14. Maiden name Mary Johnson

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

16. (a) Informant Charles Wright

(b) Address Camden, Mo.

17. (a) Burial (b) Date thereof 3-15-44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellington Mo.

18. (a) Signature of funeral director J. B. Brothers

(b) Address Richmond, Mo.

19. (a) 3/20/44 (b) Dr. G. J. Simmons
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray

(c) City or town Camden, Mo.
(If outside city or town limits, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
year 1944 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov
1942 to Mar. 13, 1944
that I last saw him alive on Mar 12, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis & Ren.

Due to Advanced Arterio-Sclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations gfa

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) (e) Means of injury _____

23. Signature W. G. Gaines M.D.

Address Richmond Mo Date signed 3-13-44

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

MOTHER FATHER

1228

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

4-12-19

Date Filed

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.....

J.B. Brothers....., Registered Apprentice No.....

working under my personal supervision.

Brothers Funeral Home .

Signed J.B. Brothers.....

Licensed Embalmer No. 3001.....

P. O. Address Richmond, 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 DEATHState File No. *April*Registration District No. *216*Primary Registration District No. *6017*Registrar's No. *7*

1. PLACE OF DEATH

(a) County *Ray Camden*
 (b) City or town *Realt*
 (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 NAME*Walford A. Johnson*3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex *M* 5. Color *W* 6. (a) Single, widowed, married,
race divorced *3*6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive years7. Birth date of deceased *Feb. 20 1906*
(Month) (Day) (Year)8. AGE: Years *17* Months Days *10* If less than one day
min.9. Birthplace *Sweden*
(City, town, or county) (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) (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
 (c) City or town (If outside city or town limits, write "RURAL")
 (d) Street No. *Rural* (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May*
year *1944* hour *10:30* minute *30* M.21. I hereby certify that I attended the deceased from
19.....; 19.....;that I last saw him alive on
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

SUPPLEMENTARY

11827