

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22032

State File No. _____

FILED JUL 15 1944

Registration District No. 204

Primary Registration District No. 3043

Registrar's No. 222

1. PLACE OF DEATH

(a) County Marion
 (b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Jawvering Hospital
(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

John Thomas Johnson

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 7 4 67
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name James Johnson
 13. Birthplace Frankford Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Laura Robinson
 15. Birthplace Frankford Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer Johnson
 (b) Address 606 John ST
 17. (a) Burial (b) Date thereof 6-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Frankford Cem

18. (a) Signature of funeral director Geo E Roberts
 (b) Address Hannibal Mo
 19. (a) 6-28-44 (b) R. H. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
 (c) City or town Hannibal
(If outside city or town limits, write "RURAL")
 (d) Street No. 606 John ST
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 7
 year 44 hour 7 minute 35 a. 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 Chf myocardite
 Duration _____

Due to _____

Due to _____

Other conditions 938
(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 J. J. Renda (M. D. or other) _____
 Address _____ Date signed _____

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

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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 *Gay Roberts*
Licensed Embalmer No. *9113*
P. O. Address *Hannibal 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.