

FILED SEP 3 1944
Registration District No. _____

Primary Registration District No. **283 5253**

Registrar's No. **3037112**

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1612 days
In this community 1612 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston
(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 Fradis Edward Johnson

3. (b) If veteran, name war Unknown 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 Rosie Jones Johnson 6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased Dec. 6th 1893
(Month) (Day) (Year)

8. AGE: Years 50 Months 8 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Ben Henry Johnson
13. Birthplace Carlyle County Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hammons
15. Birthplace Carlyle County Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San., Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof Aug 26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston Mo

18. (a) Signature of funeral director Geo B Orr

(b) Address Mo. State San., Mt. Vernon, Mo.

19. (a) Aug 26 44 (b) Audy Bandy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th
year 1944 hour 7:45 minute P M.

21. I hereby certify that I attended the deceased from March 25th 19 40 to Aug. 25 19 44
that I last saw him alive on August 25 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration Over 8 yrs.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 3rd stage thoracoplasty, infection, subcap. space
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 Y. F. Fujikawa (M. D. or other) M.D.
Address State Sanatorium, Mt. Vernon Date signed 8-25-44

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

13.34

2250
RECEIVED

District Health Officer No. 6,

District File Number 944-984

Date Filed SEP 5 1944

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.....

Licensed Embalmer No. 946

P. O. Address 7 W. Vermont

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.