

FILED OCT 13 1944

Primary Registration District No. **3012**

Registrar's No. **126**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Excelsior Springs**
(c) Name of hospital or institution **Excelsior Springs Hospital**
(d) Length of stay: In hospital or institution **3 days**
In this community **3 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ray**
(c) City or town **Rural**
(d) Street No. **Rural**
(e) Citizen of foreign country? **No**
If yes, name country **None**

3. (a) PRINT FULL NAME **LONNIE LEE JOHNSON**

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

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

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **None** years

7. Birth date of deceased **Nov. 4, 1879**

8. AGE:	Years	Months	Days	If less than one day
	64	10	5	

9. Birthplace **Wellington Mo**

10. Usual occupation **Partender**

11. Industry or business **Summer Resort**

12. Name **L. W. Johnson**

13. Birthplace **Kansas**

14. Maiden name **Mary Jane Moore**

15. Birthplace **Wellington Mo**

16. (a) Informant **Miss Mabel Whitford**

(b) Address **Excelsior Springs Mo**

17. (a) Removal **Removal** (b) Date thereof **Sept 19 1944**

(c) Place: burial or cremation **Excelsior Springs Mo**

18. (a) Signature of funeral director **H. Campbell**
(b) Address **Excelsior Springs Mo**
19. (a) **9-19-44** **Miss Sadie Redman**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19** year **1944** hour **2** minute **50** M.

21. I hereby certify that I attended the deceased from **Sept 10 - 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **None**

Other conditions **None**

Major findings: Of operations **None**

Of autopsy **None**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **None**
(b) Date of occurrence **None**
(c) Where did injury occur? **None**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **None**

While at work **None** (Specify type of place) (c) Means of injury **None**

23. Signature **S. J. Richardson** (M. D. or other) **Richardson**
Address **Excelsior Springs Mo** Date signed **9-19-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

24

Mr. Day

RECEIVED

District Health Officer No. 8,
District File Number _____

Date Filed 10-20-44

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 _____

Registered Apprentice No. _____

working under my personal supervision.

Signed *Geo. A. M. Kear*

Licensed Embalmer No. 2983

P. O. Address Lexington 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.