S. N.
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 31276

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 369

**1. PLACE OF DEATH:**

(a) County Linn

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

(c) Name of hospital or institution: Brookfield 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Hosp 4 days (Specify whether In this community 30 yrs years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Linn 58

(c) City or town Brookfield 1 (If outside city or town limits, write "RURAL") 2

(d) Street No. 221 E Park (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME WESLEY SALISBURY JOHNSON

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife: Harriet Margaret Johnson

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased June (Month) 19 (Day) 1870 (Year)

8. AGE: Years 74 Months 2 Days 25 If less than one day ___ hr. ___ min.

9. Birthplace Linn Co. Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business

FATHER
12. Name John H. Johnson
13. Birthplace Unknown 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ZELIE HUNGERFORD
15. Birthplace New York 1 (City, town, or county) (State or foreign country)

16. (a) Informant Walter H Johnson

(b) Address Brookfield Mo

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 9-16-44 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield

18. (a) Signature of funeral director C. Wright

(b) Address Brookfield Mo

19. (a) 9-15-44 (Date received local registrar) (b) H W Coman (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 14 year 1944 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from 9-12, 1944 to 9-14, 1944 that I last saw him alive on 9-14, 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Respiratory failure | |
| Due to Concussion - and fracture 3rd Cervical | |
| Due to Vertebrae | 3 days |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident 058

(b) Date of occurrence 9-10-44

(c) Where did injury occur? Highway 36 - Auto (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No (Specify type of place)

While at work? No (e) Means of injury

23. Signature C. C. Smoch D.O. (M.D. or other)

Address Brookfield Mo Date signed 9/16

(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.....

.....a Registered Apprentice No.....

working under my personal supervision.

Signed C. A. Larson

Licensed Embalmer No. 2-4-0-27

P. O. Address Bucklin Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

U. S. No. 2B
10M—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 31276

Registration District No. 184 Primary Registration District No. 2038 Registrar's No. 369

**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: Wesley S. Johnson
3. (b) If veteran, name war: U
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
7. Birth date of deceased: June (Month) 19 (Day) 1870 (Year)
8. AGE: Years 74 Months 2 Days If less than one day hr. min.
9. Birthplace (City, town, or county) MO (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 Sept. Day 4 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.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory failure | |
| Due to: Concussion - and fracture 3rd cervical vertebra | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations: TOC-8 28
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): Auto accident
(b) Date of occurrence: Sept 10, 1944
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)
U.S. Highway 36 (Specify type of place)
While at work? (e) Means of injury: Car upset
23. Signature: [illegible] M.D. (M.D. or other)
Address Date signed

SUPPLEMENTARY

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