

FILED DEC 11 1944

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 380

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Coplar Bluff
(c) Name of hospital or institution Coplar Bluff Hospital
(d) Length of stay: In hospital or institution 1/2 hours
In this community Less than 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Rural, Bernice, MO
(d) Street No.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Unnamed Infant of Thomas H. Johnson

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 21 years
7. Birth date of deceased Nov. 21 1944

8. AGE: Years Months Days If less than one day 4 hrs. min.

9. Birthplace Bernice MO

10. Usual occupation.

11. Industry or business.

12. Name Thomas H. Johnson
13. Birthplace Steele MO
14. Maiden name Bernice Williams
15. Birthplace Bernice MO

16. (a) Informant Thomas H. Johnson

(b) Address Bernice MO

17. (a) Burial (b) Date thereof Nov 22 1944

(c) Place: burial or cremation Bernice Cemetery

18. (a) Signature of funeral director Bernice MO

(b) Address Bernice MO

19. (a) 11-30-44 (b) Bill Stinne

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21
year 1944 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from 11-20, 1944, to 11-21, 1944
that I last saw him alive on 11-21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth
Due to Premature birth

Due to 15A
Other conditions 15A
(Include pregnancy within 3 months of death)

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)
(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 Wm. Hanch (M. D. or other)
Address Coplar Bluff Mo Date signed

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1244-1594

Date Filed 12-7-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.