

FILED DEC 8 1944

Registration District No. **5**

Primary Registration District No. **0259**

Registrar's No. **26**

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

1. PLACE OF DEATH:

(a) County Washington  
 (b) City or town Rural; Bellevue  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1/2 mile South of Caledonia  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 years  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank William Johnson

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

4. Sex male 5. Color or race single 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 24 1870  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>10</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace Owensburrugh Ky.  
 (City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business farm

12. Name James Johnson

13. Birthplace unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant C.L. Rhodes

(b) Address Caledonia Mo.

17. (c) burial (b) Date thereof 10-28-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Ironton Mo.

19. (a) Nov. 8, 44 (b) Olla White  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1/2 mile south of Caledonia  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27  
 year 1944 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from Oct. 10<sup>th</sup>  
1944 to Oct. 27<sup>th</sup> 1944  
 that I last saw him alive on Oct. 10<sup>th</sup> 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage (stroke)

Due to Hypertensive heart disease

Due to cataract of left eye

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 930

Of autopsy \_\_\_\_\_

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 2 mi. E.

23. Signature P. E. Harland (M. D. or other) 2 mi. E.  
 Address Ironton Mo. Date signed 10/30/44

Duration

10/27/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4  
District File Number 1244-4635  
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

*Amel J. White*

Licensed Embalmer No. 3012

P. O. Address

*Clinton, Miss.*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 365

Primary Registration District No. 6239

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Washington  
(b) City or town Rural Bellevue  
(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  
in this community \_\_\_\_\_ years, months or days)

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 Frank W. Johnson

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

4. Sex m 5. Color or race S 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased See 24 (Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director A J White

(b) Address Front st  
19. (a) \_\_\_\_\_ (b) A J White  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

39086