

I X32673

FILED FEB 5 1945
8 W

State File No. _____
Registrar's No. 6-

Registration District No. _____ Primary Registration District No. 3017

1. PLACE OF DEATH:
 (a) County COOPER
 (b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 DAYS
(Specify whether years, months or days)
 In this community FOUR DAYS

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County COOPER 27
 (c) City or town BOONVILLE 1
(If outside city or town limits, write "RURAL") 2
 (d) Street No. NONE
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country. U

3. (a) PRINT FULL NAME JONNIE JOE JOHNMEYER
 3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JANUARY day 9th
 year 1945 hour 9 minute P.M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, divorced, married, SINGLE
 6. (b) Name of husband or wife. _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased JANUARY 6 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 6 1945 to Jan 9 1945
 that I last saw him alive on Jan 9 1945
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>4</u>	hr. _____ min. _____

Immediate cause of death. Cerebral Hemorrhage 1 day

9. Birthplace BOONVILLE MISSOURI
(City, town, or county) (State or foreign country)

Due to Birth injury
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 1600

10. Usual occupation INFANT

Major findings: Of operations none
 Of autopsy none

11. Industry or business _____
 12. Name CASPER W. JOHNMEYER
 13. Birthplace COOPER COUNTY MISSOURI
 14. Maiden name FLORENCE ELIZABETH SCHLES
 15. Birthplace OVERTON MISSOURI
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant C.W. JOHNMEYER
 (b) Address BOONVILLE, MO.

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? _____

17. (a) BURIAL (b) Date thereof JAN. 10, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation WALNUT GROVE CEMETERY

While at work? _____
(Specify type of place) (e) Means of injury

18. (a) Signature of funeral director STEGNER & KOENIG
 (b) Address BOONVILLE, MO.
 19. (a) Jan-10-45 (b) Dr Chas. Swap
(Date received local registrar) (Registrar's signature)

23. Signature J.C. Beckett M.D.
 Address Boonville mo Date signed 1-11-45

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

7
29

RECEIVED

District Health Officer No. 8,

File Number 2-1-42

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 James W. Segner
Licensed Embalmer No. 3780
P. O. Address Boonville, 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.