

FILED JAN 19 1945  
Registration District No. 277

Primary Registration District No. 3045  
State File No. \_\_\_\_\_  
Registrar's No. 99

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston  
(c) Name of hospital or institution:  
626 W. Marshall  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss. 67  
(c) City or town Charleston  
(d) Street No. 626 W. Marshall  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

3. (a) PRINT FULL NAME James Phillip Johnson  
3. (b) If veteran, name war ----  
3. (c) Social Security No. ----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5th  
year 1944 hour 3 minute 10 P M.

4. Sex M 5. Color or race Colored  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Della Johnson  
6. (c) Age of husband or wife if alive 59 years  
7. Birth date of deceased February 28th 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 9-22-1944 to 11-17-1944  
that I last saw him alive on 11-17-44 and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 9 Days 7  
If less than one day hr. min.

Immediate cause of death:  
Supertensive Heart Disease & Left Hemiplegia  
Duration 8mons

9. Birthplace Searcy Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Due to Chronic nephritis 1yr!

Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name James Anderson Johnson  
13. Birthplace Tenn  
14. Maiden name Mary Ellen Smith  
15. Birthplace Ark.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations 1314  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Della Johnson  
(b) Address Charleston, Mo.  
17. (a) Burial (b) Date thereof 12-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? Mo.

(c) Place: burial or cremation Oak Grove Charleston Mo.  
18. (a) Signature of funeral director John F. Zimmerman  
(b) Address Charleston Mo  
(c) (Date received local registrar) (Registrar's signature) Mrs. M. A. Moore

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Mean of injury 0  
23. Signature W. A. Sinal (M. D. or other)  
Address: 204 S. Locust St. Charleston Mo. Date signed 12-6-44

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

7  
2

1257

RECEIVED  
District Health Office No. 2,  
District File Number 145-95  
Date Filed 1-16-45

**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 John F. Nunnally Jr  
Licensed Embalmer No. 3851  
P. O. Address Charleston, Wv

**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.**