7. S. No. 2
DM—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 2 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16420

Registration District No. 42 Primary Registration District No. 1 Registrar's No. 583

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Hospital 4 W
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1316 Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Johnnie ALLIE TOWNSON
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife: X
6. (c) Age of husband or wife if alive: X years
7. Birth date of deceased: May (Month) 6 (Day) 1905 (Year)
8. AGE: Years 40 Months 0 Days 22 If less than one day hr. min.
9. Birthplace: Oklahoma (City, town, or county) — (State or foreign country)
10. Usual occupation: Factory worker
11. Industry or business: Garments
MOTHER FATHER
12. Name: Thomas Townson
13. Birthplace: Ga (City, town, or county) (State or foreign country)
14. Maiden name: Mary Johnson
15. Birthplace: Ga (City, town, or county) (State or foreign country)
16. (a) Informant: Sallie Young
(b) Address: Fredonia Kas
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-29-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Fredonia Kans.
18. (a) Signature of funeral director: Pleeman & Son Inc
(b) Address: 1946 Calhoun St. Joseph
19. (a) 5-29-45 (Date received local registrar) (b) Glen J. Pickel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28 year 1945 hour 7:30 minute P. M.
21. I hereby certify that I attended the deceased from May 20, 1945, to May 28, 1945, that I last saw him alive on May 28, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial pneumonia	8 day
Due to: Syphilis (Sepsis)	4 years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: 30%	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: L. F. Shuck (M. D. or other)
Address: State Hosp. #2 St Joseph, Mo Date signed 5/29/45

1511 (Licensed Embalmer's Statement on Reverse Side)

JUN 1 1948

MAR 13 1948

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St Joseph 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.