

FILED MAY 18 1945

Registration District No. 2-23

Primary Registration District No. 67.5-3074

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(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 50 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott
(c) City or town Sikeston
(d) Street No. Route 2
(e) Citizen of foreign country? no (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME LEMUEL MARTIN JOHNS

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, widowed
6. (b) Name of husband or wife Lula 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 15 1862 (Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace W. Va. (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
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 Bishop Johns

(b) Address Sikeston Mo R #1

17. (a) Burial (b) Date thereof 2-24-45 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo

18. (a) Signature of funeral director W. L. L. Funeral Home

(b) Address Sikeston Mo

19. (a) 5/16/45 (b) L. L. L. Registrar (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1945 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb 1-45 to Feb 22 1945 that I last saw him alive on Feb 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Older mania Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____ ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 E. J. Hien (M. D. or other) _____ Address Sikeston Mo Date signed 2/26/45

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

RECEIVED

District Health Office No. 2

District File Number 545-740

Date Filed 5-15-45

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. _____

Registration District No. 223

Primary Registration District No. 3074

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sekeston
(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 years, months or days)

3. (a) PRINT FULL NAME Samuel M. Johns

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 15
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days _____ If less than one day hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) W. Va

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1964 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Total Pulmonary Embolism

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

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 _____

23. Signature Ed Mienstedt (M. D. or other)

Address Sekeston Mo Date signed 5-23-65

SUPPLEMENTARY

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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