

FILED SEP 4 1945 43  
District No. \_\_\_\_\_

Primary Registration District No. 1000

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

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: State Hospital # 7  
(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)

In this community 6 yrs 4 mo 20 da  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town McC 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 1328 E 17th 7  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME TILLIE JOHNSON

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

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Ernest Johnson 6. (c) Age of husband or wife, if alive not given years

7. Birth date of deceased not given  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18  
year 1945 hour 6:45 minute a M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to Aug 18 1945  
that I last saw him alive on Aug 17 1945, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>			hr. _____ min. _____

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

10. Usual occupation maid

Immediate cause of death: Septicemic Duration 6 yrs

Due to Syphilis 6 yrs

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

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

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

12. Name not given

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

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

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

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations none

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

Underline the cause to which death should be charged statistically.

16. (a) Informant Ernest Johnson

(b) Address 1328 E 17th McC

17. (a) Burial (b) Date thereof Aug 21 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Asylum Cemetery

18. (a) Signature of funeral director E. J. Ramsey

(b) Address 1602 Mission St

19. (a) 8-21-45 (b) Hee-nel P. Baker  
(Date received local registrar) (Registrar's signature)

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

Address State Hospital # 7 Date signed 8/18/1945

**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 J. F. Ramsey  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed J. F. Ramsey  
Licensed Embalmer No. 4081  
P. O. Address: 1602 Mission

**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.**