

FILED AUG 22 1945

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 3036

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Lawrence  
 (b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
136 East Springfield St  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community 2041  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence  
 (c) City or town Aurora  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 136 E Springfield St.  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Q. A. Johnson

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

4. Sex M 11 race W 5. Color or \_\_\_\_\_  
 6. (a) Single, widowed, married, divorced MARRIED!

6. (b) Name of husband or wife Elizabeth alive \_\_\_\_\_ years  
 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Jun 15 1866  
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 15 If less than one day \_\_\_\_\_  
hr. min.

9. Birthplace Farmer Tenn \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Bill Johnson

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

14. Maiden name unknown

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

16. (a) Informant Dice Evans

(b) Address Aurora MO

17. (a) burial (b) Date thereof 8/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Q.A. Cemetery

18. (a) Signature of funeral director Edward Marshall

(b) Address Aurora MO

19. (a) 8-5-45 (b) Eunice Green  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from one visit  
July 27, 1945 to date of death, 1945,  
 that I last saw him alive on July - 27, 1945,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
 Due to Hypertension  
 Due to senility

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: nope  
 Of operations \_\_\_\_\_

Of autopsy no Autopsy

Duration  
3 day

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 H. L. Kerr (M. D. or other) \_\_\_\_\_  
 Address Crane Mo. Date signed Aug 45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 845-893

Date Filed AUG 20 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.....

Myself, Registered Apprentice No.....  
working under my personal supervision.

Signed Ben L. Marsh

Licensed Embalmer No. 3872

P. O. Address Lawrence, 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.