

FILED AUG 28 1945

Registration District No. ....

Primary Registration District No. 5808

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Montgomery  
(b) City or town High Hill Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 5 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State California (b) County Los Angeles  
(c) City or town Los Angeles Calif  
(If outside city or town limits, write "RURAL")  
(d) Street No. 47  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

JAMES EDWARD JOHNSON

3. (b) If veteran, name war

3. (c) Social Security No. 550-09-5169

4. Sex MALE

5. Color or race BLACK

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

6. (b) Name of husband or wife MRS EDWARD JOHNSON  
6. (c) Age of husband or wife if live 11 1/2 years

7. Birth date of deceased DEC 6 1885  
(Month) (Day) (Year)

8. AGE: Years 59 Months 8 Days 4  
If less than one day hr. min.

9. Birthplace Montgomery Co Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Frank Johnson

12. Name Frank Johnson

13. Birthplace Warren Co Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Euanda Johnson

15. Birthplace Warren Co Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Josephine Hinton

(b) Address St Louis Mo

17. (a) burial (b) Date thereof Aug 14 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City Calif

18. (a) Signature of funeral director Martha + Edwell  
(b) Address Montgomery City Mo

19. (a) Aug 23rd 45 (b) Lillie J Gibbs  
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10 year 1945 hour 7 minute P M.

21. I hereby certify that I attended the deceased viewed FRIDAY 10th AUGUST 1945 to 11:30 AM.  
that I last saw alive on FRIDAY and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration

Due to

Due to

Other conditions 830  
(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 fall

23. Signature Charles R. ... (M. D. or other)

Address Montgomery City Mo Date signed 12 Aug 45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

8-27-45

SEP 6 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 \_\_\_\_\_

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.