

**FILED** DE 28 1945  
Registration District No. ....

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Springfield Baptist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days (Specify whether  
In this community 3 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas  
(c) City or town Ava  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. ....

3. (a) PRINT FULL NAME JAMES FRANCIS JOHNSON

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Manda Johnson 6. (c) Age of husband or wife if alive 12 years  
7. Birth date of deceased June 12, 1889  
(Month) (Day) (Year)

8. AGE: Years ✓ 76 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Christian County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Carptener

11. Industry or business

MOTHER FATHER { 12. Name William Johnson  
13. Birthplace Unknown Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Jones  
15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Johnson

(b) Address 1851 N. Broadway Ave. Spfld, Mo.

17. (a) Burial (b) Date thereof 11/21/1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address 534 St. Louis, Springfield, Missouri

19. (a) 11-23-45 (b) S. W. E. Handley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 18,  
year 1945 hour 10: minute 30 P.A.M.

21. I hereby certify that I attended the deceased from Nov 17 1945 to Nov 18 1945  
that I last saw him alive on Nov 18 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic pyonephrotic  
Prostate obstruction Duration 48 hrs  
5yr

Due to Prostate obstruction 5yr

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations No operation  
Of autopsy 1330

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) .....

(c) Where did injury occur? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

(Specify type of place)

While at work? (Specify type of place) (e) Means of injury

23. Signature Roy Johnson (M. D. or other)

Date signed 11/23/45

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

37  
55

DEC 13 1945

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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.**