

No. 2-43
17-39
X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38128

FILED DEC 12 1945

State File No. _____

Registration District No. 270

Primary Registration District No. 30.50

Registrar's No. 95

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Cauthersville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
(c) City or town Cauthersville
(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 _____

3. (a) PRINT FULL NAME Jimmie Harry Johnson

3. (b) If veteran name was _____ 3. (c) Social Security No. 1

4. Sex M O 5. Color or race W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Oct 21 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
Only 21 days hr. _____ min. _____

9. Birthplace Cauthersville Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Edgar Willie Johnson

13. Birthplace Daxton Laurens
(City, town, or county) (State or foreign country)

14. Maiden name Norma C. Smith

15. Birthplace Missola Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Edgar W. Johnson

(b) Address 204 W. 14th St.

17. (a) Burial (b) Date thereof 11-13-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Miami Cemetery

18. (a) Signature of funeral director La Forge and Co.

(b) Address Cauthersville

19. (a) 12-5-45 (b) J. B. Wilko
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
19 _____ to _____ 19 _____

that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation
(Accidental) Sudden
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)
(?) Means of injury _____

23. Signature [Signature] (M. D. or other)
Address Cauthersville 11/16/45

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

11-45-221

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..... *Noel C. Dean*

Licensed Embalmer No. *3941*

P. O. Address..... *Caruthersville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 270 Primary Registration District No. 3050

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Caruthersville
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Jimmie H. Johnson

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 s

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 27
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ Day _____ Year _____
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

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) Accident

(b) Date of occurrence Nov 18 1959

(c) Where did injury occur? Caruthersville Mo
(City or town) (County) (State)

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

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

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 11/15/59

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

38128