

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

FILED JAN 11 1946
Registration District No. 372

Primary Registration District No. 6264

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Weberster
(b) City or town Seymour Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Haywood Tex. 1
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Weberster 112
(c) City or town Seymour Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Haywood Tex. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Kenneth Duane Johnson

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

4. Sex M. O 5. Color or race W. 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Mar 7 1945
(Month) (Day) (Year)

8. AGE: Years 2 Months 8 Days 20 If less than one day hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Ella Johnson

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

14. Maiden name Hode

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

16. (a) Informant Ella Johnson

(b) Address Seymour Mo

17. (a) Burial (b) Date thereof Nov 27 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Dale Home

18. (e) Signature of funeral director Kelley Funnel

(b) Address Seymour Mo

19. (a) Dec 10 (b) Gilbert Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1945 hour 8 minute 30 AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Burned to Death when the home was destroyed by fire Duration _____

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) _____ 112

(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 K. H. Kelley (M. D. or other) _____

Address Seymour Mo Date signed CO

1667

11-26-1945

RECEIVED
District Health Officer No. 6,
District File Number 146-61
Date Filed JAN 9 1970

This body was not embalmed

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 24

Registration District No. 372

Primary Registration District No. 6264

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Rural
(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 Kenneth D 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..... years

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

8. AGE: Years Months Days If less than one day
2 9 20 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (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..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death..... Duration.....

Due to.....
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUIRED**

Major findings: Of operations.....

Of autopsy.....

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) Accident

(b) Date of occurrence..... 11-26-45

(c) Where did injury occur?..... (City or town) (County) (State)
Imbela Co. MO

(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 J. B. Kelley (M. D. or other) Date signed.....
Address.....

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

SUPPLEMENTARY

42792