

FILED MAR 27 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 28

1. PLACE OF DEATH

(a) County Randolph
(b) City or town Proberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institutions 611 Cleveland
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
In this community 41 years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Proberly
(If outside city or town limits, write "RURAL")
(d) Street No. 611 Cleveland
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH CURTLY JOHNSON

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Carrie Johnson 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased January - 30 - 1864
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation (Retired) Druggist

11. Industry or business _____

12. Name David Johnson

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

14. Maiden name Sarah Chappell

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

16. (a) Informant Mrs. Carrie Johnson

(b) Address 611 Cleveland Proberly Mo

17. (a) Burial (b) Date thereof Feb 7 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Proberly Mo

18. (a) Signature of funeral director Funeral Home

(b) Address Proberly Mo
(c) Date received local registrar 2-1-46 (d) W. H. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31st
year 1946 hour one minute 15 AM

21. I hereby certify that I attended the deceased from Jan - 1 - 1946 to Jan - 31 - 1946
that I last saw him alive on Jan - 17 - 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Duration Several years

Due to Old age

Due to _____

Other conditions _____
(Include pregnancy within 3 months)

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature W. H. Williams (M. D. or other)
Address Proberly Mo Date signed 2-31-46

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-46-589

Date Filed MAR-1-9-1946

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Proberly M.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *April*

Registration District No. *29F*

Primary Registration District No. *3036*

Registrar's No. *28*

1. PLACE OF DEATH:

(a) County *Randolph*
(b) City or town *Moberly*
(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 *Joseph C. 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 _____

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

7. Birth date of deceased *Jan 30 1966*
(Month) (Day) (Year)

8. AGE: Years *82* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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 _____

(a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

(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 *1946* hour _____ minute _____ M.

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 _____

Extensive Arteriosclerosis Duration *several years*

Due to *Old Age*

Due to _____

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

Major findings: Of operations _____

Of autopsy *a1*

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 *E. H. Shrader* (M. D. or other) _____

Address *Moberly, Mo* Date signed *3/13/46*

SUPPLEMENTARY

MOTHER FATHER

932

10457

10457