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**FILED** MAR 27 1946  
Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moulton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Wabash Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 8 days (Specify whether)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Appanoose 999

(c) City or town Moulton 1.3  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 21

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Orville Johnson

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

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Edith Johnson 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased Nov 26 1912  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

34 3 10 hr. min.

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

10. Usual occupation Mechanic

11. Industry or business Wabash RR

12. Name Selva Johnson

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

14. Maiden name no data

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

16. (a) Informant Selva Johnson

(b) Address De Moines Ia

17. (a) Removal (b) Date thereof 2-16-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moulton Ia

18. (a) Signature of funeral director H. L. Eagle

(b) Address Moulton Ia.

19. (a) Feb 16-46 (b) Leah Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from February 12, 1946, to Feb 16, 1946, that I last saw him alive on February 16, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Secondary Shock  
Uncontrollable Hemorrhage

Due to Malignancy of Upper Abdomen

Due to smoking Walled bladder, Swart Pancreas

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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 \_\_\_\_\_

23. Signature John A. Maczuga MD (M. D. or other)

Address Wabash Baptist Hospital Date signed Feb 16, 1946

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JUN 18 1946

RECEIVED

District Health Officer No. 10

District File Number 3-46-59

Date Filed MAR 19 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 \_\_\_\_\_

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.

*Not Embalmed*

Registration District No. 294 Primary Registration District No. 3056

1. PLACE OF DEATH:  
(a) County Randolph  
(b) City or town Makerly  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Orville Johnson  
3. (b) If veteran, name war \_\_\_\_\_ (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 \_\_\_\_\_  
7. Birth date of deceased Nov. 26 1919  
(Month) (Day) (Year)

8. AGE: Years 34 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Jawa  
(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 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to Primary Site of Cancer  
could not be ascertained

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_  
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) (e) Means of injury \_\_\_\_\_  
23. Signature John D. Maczuga MD (M. D. or other)  
Address Webb's Hospital Date signed 3-31-46

**SUPPLEMENTARY**

9371 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

JUN 18 1946

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