

FILED MAY 7 1946

State File No. _____

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 100

1. PLACE OF DEATH:
 (a) County Boone
 (b) City or town Columbia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
111 N. 3rd St. 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 52 years
 years, months or days

3. (a) PRINT FULL NAME WALTER JOHNSON
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced, divorced
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 1-1-1894
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 3 25 hr. min.

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

10. Usual occupation Truck driver

11. Industry or business Boone Company

12. Name Fred Johnson
 13. Birthplace Boone Co. Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Bertie Bradford
 15. Birthplace Boone Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Lucile Knox
 (b) Address Columbia Mo.

17. (a) Burial (b) Date thereof 4-29-1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boys Rovers Mo.
 18. (a) Signature of funeral director Walter A. Parker
 (b) Address Columbia Missouri

19. (a) 5-1-46 (b) Mrs. R. E. Palmer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone 10
 (c) City or town Columbia 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 111 N. 3rd St. 4
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 26
 year 1946 hour 4 AM minute _____ M.
 21. I hereby certify that I attended the deceased 4-22-46
 that I last saw him alive on 4-23-46
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Due to Had flu about a month before
 Due to _____

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

Major findings: Of operations none
 Of autopsy none

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) (a) Means of injury _____
 23. Signature W. A. Parker (M. D. or other) _____
 Address Columbia Mo. Designated _____

Duration few days
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

RECEIVED

District Health Officer No

District File Number

Date Filed 5-4-46

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

working under my personal supervision.

Signed

Registered Apprentice No.
Sharon D. Parker

Licensed Embalmer No.

P. O. Address

2900

Columbus, Ga.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. May
Registrar's No. 1000

Registration District No. 38 Primary Registration District No. 3006

1. PLACE OF DEATH:
(a) County Boone Columbia
(b) City or town _____
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Walter Johnson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Jan (Month) 3 (Day) 1946 (Year)
8. AGE: Years 52 Months 3 Days 3 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 _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 5-1-46 (b) Mrs R E Palmer
(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 _____ Year 1946 hour _____ minute _____ M. 26
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)
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) _____
(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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY RECORD

12181