

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15536

State File No.

FILED MAY 14 1946

Registration District No.

Primary Registration District No. 6276

Registrar's No. 20

1. PLACE OF DEATH:

(a) County North
(b) City or town Rural - Union township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sheridan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community 2 yrs
years, months or days)

3. (a) PRINT FULL NAME

Frank 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 single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive. years
7. Birth date of deceased June 21 1980
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 19 hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Moses C. Johnson
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Rosetta Small
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant John Tippie
(b) Address Sheridan, Mo.

17. (a) burial (b) Date thereof 3-11-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director John C. Dunfee

(b) Address Grant City, Mo.

19. (a) April 19-46 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. near Sheridan
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 10
year 1946 hour 12 minute 10 A. 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 Mitral regurgitation of aorta Duration 15 mo

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 John C. Dunfee (Name or other)
Address Grant City Mo. Date signed 3-11-46

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

Arch C. Duffee

Licensed Embalmer No. *3252*

P. O. Address.....

Grant City, Mo

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.