

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 25 1946  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4018

Registrar's No. 352

1. PLACE OF DEATH:

(a) County Janey

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

(c) Name of hospital or institution: Williams Nursing Home  
(If not in hospital or institution, write street number and location) 4

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community several years  
years, months and days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Janey

(c) City or town Hollister MO  
(If outside city or town limits, write "RURAL.")

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

(e) Citizen of foreign country? U.S.A. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) James Franklin Johnson  
FULL NAME

3. (b) If veteran, name war no.

3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W 6. (a) Single, widowed, ~~married~~, divorced 2 times

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased Dec 29 1868  
(Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired furniture repair man

11. Industry or business \_\_\_\_\_

12. Name Wagon L. Johnson

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

14. Maiden name Martha C. Johnson

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

16. (a) Informant G. O. Johnson

(b) Address Kansas City MO

17. (a) Buried (b) Date thereof July 16 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Branson MO

18. (a) Signature of funeral director R. O. Whitche

(b) Address Branson MO

19. (a) July 16 46 (b) Arthur Branson  
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13 day July  
year 1946 hour 9:00 minute 7 M.

21. I hereby certify that I attended the deceased from Mar 7 46 to July 13 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations 82%

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

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)

(c) Means of injury \_\_\_\_\_

Signature Dr. Roberts (M.D. or other) \_\_\_\_\_  
Date signed 7/15/46

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

24854

RECEIVED

District Health Officer No. 6,

District File Number 746-768

Date Filed JUL 23 1946

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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 Miriam L. Welchel

Licensed Embalmer No. 2277

P. O. Address Branston no.

**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.