

**FILED** SEP 12 1946

Registration District No. 226

Primary Registration District No. 5800

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Monroe  
 (b) City or town Santa Fe, MO  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
 (c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 909 W. Rollins  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

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3  
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3. (a) PRINT FULL NAME James Earl Johnson

3. (b) If veteran,  name war..... 3. (c) Social Security No. 489-10-9758

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased: Feb 4<sup>th</sup> 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 6 27 hr. min.

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

10. Usual occupation Engineer

11. Industry or business Sinclair Coal Co

MOTHER FATHER { 12. Name George W Johnson  
 13. Birthplace Miss  
(City, town, or county) (State or foreign country)  
 14. Maiden name Roxana Sider  
 15. Birthplace Ala  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Helen Johnson

(b) Address Moberly, Mo

17. (a) Removal (b) Date thereof Sept 2<sup>nd</sup> 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tulsa, OKla.

18. (a) Signature of funeral director Mahon and Son

(b) Address Moberly Mo

19. (a) Sept 3, 1946 (b) Chas Little  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31<sup>st</sup>  
 year 1946 hour 2 minute R M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death accidental death by dropping of drag line, crushing head - while drag line was in use

Due to use

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy no

Duration

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) Accident

(b) Date of occurrence Aug 31 - 1946

(c) Where did injury occur? Monroe Missouri  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on farm

While at work? yes (Specify type of place) (e) Means of injury head

23. Signature Quinn M Wilson (M. D. or other) Coroner

Address Monroe City, Mo Date signed Sept 2, 1946

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

RECEIVED  
District Health Officer No. 10  
District File Number 9-46-1734  
Date Filed SEP 11 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 Frank D. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly, Mo

Notes: 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.

RECEIVED

Registration District No. 226 Primary Registration District No. 5800

1. PLACE OF DEATH:

(a) County Memor

(b) City or town Santa Fe, Mo.  
(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 James E. 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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Feb 4  
(Month) (Day) (Year)

8. AGE: Years 52 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(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) Oliver Little  
(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. \_\_\_\_\_

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 \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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

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

Major findings:  
Of operations \_\_\_\_\_

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)  
(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRIT. P. Y.—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

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