

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 340

1. PLACE OF DEATH:

(a) County Calloway

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

(c) Name of hospital or institution: State Hospital no 12  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo 2 day  
(Specify what)

In this community same  
years, months or days

3. (a) PRINT FULL NAME THOMAS 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 widowed

6. (b) Name of husband or wife ok

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

7. Birth date of deceased PK  
(Month) (Day) (Year)

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation same

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

MOTHER FATHER

12. Name Sam Johnson 9

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

14. Maiden name Ruth Pearson 9

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Records State Hospital no 1

(b) Address Fulton

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-21-1946  
(Month) (Day) (Year)

(c) Place: burial or cremation Columbia MO

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia MO

19. (a) 10-21-1946 (Date received local registrar) (b) Jessie Mouskoff (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

(c) City or town Muscow 1  
(If outside city or town limits, write "RURAL")

(d) Street No. East Bentwood 2  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1946 hour 7 minute 45 M.

21. I hereby certify that I attended the deceased from Oct 16 to Oct 17 that I last saw him alive on Oct 17 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

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

Other conditions Renal Paren  
(Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy none made

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 J. O. Roberts (M. D. or other) 10-21-1946  
Address Fulton Day signed

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

31740

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 10-28-46

NOV 1 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.