

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS
FILED JAN 27 1947THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1952

State File No. _____

Registration District No. 231Primary Registration District No. 3048Registrar's No. 10

1. PLACE OF DEATH:

(a) County NODAWAY
 (b) City or town MARYVILLE
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST. FRANCES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether
 In this community 83 yrs years, months or days)

3. (a) PRINT FULL NAME DAVID 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 W

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

7. Birth date of deceased Sept 17 - 1863
(Month) (Day) (Year)8. AGE: Years 83 Months 3 Days 22 If less than one day _____ hr. _____ min.9. Birthplace Andrew Co Mo
(City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Pol K. Johnson13. Birthplace un known un known
(City, town, or county) (State or foreign country)14. Maiden name un known15. Birthplace un known
(City, town, or county) (State or foreign country)16. (a) Informant Norris Johnson(b) Address Savannah Mo17. (a) B. (b) Date thereof 1-11-1947
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Savannah Mo18. (a) Signature of funeral director E. C. Burt(b) Address Savannah Mo19. (a) Jan 14-47 (b) Beas Bolt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Savannah
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 9
year 1947 hour 5 minute _____ P.M.21. I hereby certify that I attended the deceased from 1-6 to Jan 9, 1947that I last saw him alive on Jan 9, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Uremia - 5 days.
Hypostatic Pneumonia - 2 days
(Terminal)

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 Robert B. Kelly (M. D. or other) _____Address Savannah Mo Date signed 1-10-47

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

MOTHER FATHER

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(Licensed Embalmer's Statement on Reverse Side)

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 E. C. Breit
Licensed Embalmer No. 2650
P.O. Address Savannah 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.