

FILED MAR 12 1947

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **40**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Laughlin Hospital**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether
In this community **all of life** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Adair**
(c) City or town **Kirkville**
(If outside city or town limits, write "RURAL")
(d) Street No. **603 So. Fille**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **JOSEPH E. JOHNSON**

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex **MD** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W 21**
6. (b) Name of husband or wife **Eliza** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan 19 1871**
(Month) (Day) (Year)

8. AGE: Years **76** Months **0** Days **27** If less than one day hr. _____ min. _____

9. Birthplace **Schuyler W MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Farmer**

12. Name **Elias Johnson**
13. Birthplace **Florida MO**
(City, town, or county) (State or foreign country)
14. Maiden name **Larandine Bequith**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Homer Johnson**

(b) Address **Kirkville MO**

17. (a) **Burial** (b) Date thereof **2-18-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jimtown Cem.**

18. (a) Signature of funeral director **Summers Powell**

(b) Address **Kirkville MO**

19. (a) **2-20-47** (b) **Wate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16** year **1947** hour **10** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **Feb. 13** 1947 to **Feb. 16** 1947
that I last saw him alive on **Feb. 16** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **3 days**
Due to **Hypertension** ?

Due to _____
Other conditions **§ 3A**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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) _____ Means of injury **2**
23. Signature **P. T. Rhoads** M.D. or other _____
Address **Kirkville, MO** Date signed **2-16-47**

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

MOTHER FATHER

MAY 13 1948

RECEIVED
District Health Officer No. 10
District File Number 3-47-429
Date Filed MAR 11 1947

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.