

DEPARTMENT OF HEALTH
 BUREAU OF THE CENSUS
FILED APR 14 1947

THE STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 139 Primary Registration District No. 55-30 4221 Registrar's No. 14

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

1. PLACE OF DEATH:
 (a) County Holt
 (b) City or town Mound City, 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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Holt
 (c) City or town Mound City, Mo.
(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 _____

3. (a) PRINT FULL NAME Edwin Stillman Johnson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 23 1851
(Month) (Day) (Year)

8. AGE: Years 96 Months 6 Days 6
 If less than one day _____ hr. _____ min.

9. Birthplace Hockingsport Ohio.
(City, town, or county) (State or foreign country)
 10. Usual occupation Farmer.
 11. Industry or business _____

MOTHER FATHER
 12. Name Danial Johnson.
 13. Birthplace Unknown.
 14. Maiden name Elizabeth Tibbles
 15. Birthplace Unknown
 16. (a) Informant Mrs. Charley Reeves.
 (b) Address Mound City, Mo.
 17. (a) Burial (b) Date thereof 3/31/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Oregon, Mo.

18. (a) Signature of funeral director W. Crawford
 (b) Address Mound City, Mo.
 19. (a) 3-31-47 (b) J. Gray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 3/29/ day 29
 year 1947 hour 2 minute 15 AM.
 21. I hereby certify that I attended the deceased from March 15
 1947 to March 29, 1947
 that I last saw him alive on March 28, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 14 days

Due to _____
 Due to _____
 Other conditions 83A
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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 F. E. Hogan M.D. or other) _____
 Address Mound City Date signed 3/31/47

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**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.....

W. L. Crawford

Licensed Embalmer No. *1824*

P. O. Address.....

Marion City, 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.