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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17904
Registrar's No. 17

Registration District No. 167 Primary Registration District No. 5608

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

1. PLACE OF DEATH:
(a) County JOHNSON
(b) City or town RURAL - MADISON TOWNSHIP
(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) A
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community SIX MONTHS years, months or days

3. (a) PRINT FULL NAME CHARLES GUSTAV JOHNSON
3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife FRANCES M. McCANDLES 6. (c) Age of husband or wife if alive L years
7. Birth date of deceased AUGUST 28 1855
(Month) (Day) (Year)

8. AGE: Years 91 Months 8 Days 10 If less than one day hr. min.

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

10. Usual occupation CIGAR MANUFACTURER

11. Industry or business _____

12. Name OKAYAS JOHNSON 4

13. Birthplace SWEDEN (City, town, or county) (State or foreign country) 4

14. Maiden name GUSTAVA 4

15. Birthplace SWEDEN (City, town, or county) (State or foreign country) 4

16. (a) Informant WAYNE H JOHNSON

(b) Address KANSAS CITY, MO.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 5-10-47 (Month) (Day) (Year)

(c) Place: burial or cremation PAOLA, KAN.

18. (a) Signature of funeral director E. B. Cant

(b) Address Holden, Mo

(c) 5-9-47 (Date received local registrar) (d) Mrs G. D. Redford (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County Johnson 51
(c) City or town RURAL (If outside city or town limits, write "RURAL")
(d) Street No. 5 MI. N. HOLDEN, MO. (If rural, give location)
(e) Citizen of foreign country? NATURALIZED (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1947 hour 4 minute 40 P.M.
21. I hereby certify that I attended the deceased from April 23 1947 to May 8 1947
that I last saw him alive on May 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____
Due to _____
Due to _____

Other conditions Sen Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy 938
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 0

23. Signature Kelly Rawlins (M. D. or other) _____
Address Holden Mo Date signed 5/9/47

JUL 15 1946
JUL 16 1949

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. B. Curt*

Licensed Embalmer No. *4059*

P. O. Address. *Holden, 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. b

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *June*Registrar's No. *17*Registration District No. *167*Primary Registration District No. *5608*

1. PLACE OF DEATH:

(a) County *Johnson*
(b) City or town *rural*
(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 days3. (a) PRINT FULL NAME *Charles G. 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 *wid*

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

7. Birth date of deceased _____
(Month) (Day) (Year)8. AGE: Years *71* Months _____ Days _____ (Unless than one day)
hr. _____ min. _____9. Birthplace _____
(City, town, or county) (State or foreign country) *Sueden*

10. Usual occupation _____

11. Industry or business _____

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) *May 9, 1947* (b) *Mrs. G. O. Redford*
(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 *1947* hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death _____
Duration _____

Due to _____

Due to _____

Other conditions _____
(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

1311

17904