

**FILED OCT 10 1947**

Registration District No. **370**

Primary Registration District No. **6151**

Registrar's No. **25**

**1. PLACE OF DEATH:**

(a) County **Stoddard**  
(b) City or town **Lavalle**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. **Apr. 2 yrs.** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Stoddard**  
(c) City or town **Lavalle**  
(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

3. (a) PRINT FULL NAME **Robert Lee Johnson**

3. (b) If veteran, name war **L** 3. (c) Social Security No. **NONE**

4. Sex **M 2** 5. Color or race **R** 6. (a) Single, widowed, married, divorced **—**

6. (b) Name of husband or wife **F** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **Sept 27 45**  
(Month) (Day) (Year)

8. AGE: Years **1** Months **11** Days **16** If less than one day hr. min.

9. Birthplace **New Madrid Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **—**

11. Industry or business **—**

12. Name **Lusher Johnson**

13. Birthplace **Mississippi**  
(City, town, or county) (State or foreign country)

14. Maiden name **Tola Wheeler**

15. Birthplace **Mississippi**  
(City, town, or county) (State or foreign country)

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

(b) Address **Lavalle Mo.**

17. (a) **Burial** (b) Date thereof **Sept 14 47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sweet Home Cem.**

18. (a) Signature of funeral director **Bernie Mo.**

(b) Address **Bernie Mo.**

19. (a) **10-4-47** (b) **Lottie Jefferson**  
(Date received local registrar) (Registrar's signature) **257**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Sept** day **12** 19**47**  
year hour minute M.

21. I hereby certify that I attended the deceased from **June 13** 19**47** to **Sept 12** 19**47**  
that I last saw him alive on **Sept 3** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **nephritis, acute glomerular**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **120**  
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 **0**

23. Signature **Geo W. Fisher** (M. D. or other)

Address **Parma Mo.** Date signed **9/19/47**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1042-1311

Date Filed 10-9-47

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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.**