

FILED JAN 5 1948

Registration District No. **164**

Primary Registration District No. **2032**

Registrar's No. **139**

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Warrensburg**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
800 West Gay 1
(If not in hospital or institution, give street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **94 years**

3. (a) PRINT FULL NAME **Henry Johnson**

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

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Anna Johnson** 6. (c) Age of husband or wife if alive **83 years**
7. Birth date of deceased **Oct 16 1853**
(Month) (Day) (Year)

8. AGE: Years **94** Months **2** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Johnson County** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Alfred Johnson**

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

14. Maiden name **Clara Johnson**

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

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

(b) Address **Warrensburg Mo.**

17. (a) **Burial** (b) Date thereof **12-24-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Warrensburg Mo.**

18. (a) Signature of funeral director **F. L. Schlegel**

(b) Address **Warrensburg Mo.**

19. (a) **Dec. 22, 1947** (b) **Savannah** (Registrar's signature) (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**
(c) City or town **Warrensburg** (If outside city or town limits, write "RURAL")
(d) Street No. **800 West Gay** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **21** year **1947** hour **11** minute **08** P.M.

21. I hereby certify that I attended the deceased from **Dec 21 at 2:00** 1947 to **Dec 21 at 11:00** 1947.
that I last saw him alive on **Dec 21** 1947 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral embolism** Duration **4 days**

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 _____

Signature **J. Reed Mahon M.D.** (M. D. or other)

Address **Warrensburg Mo.** Date signed **Dec 22**

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

MOTHER FATHER

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.....

Francis Lee Schoburg, Registered Apprentice No. *464*
working under my personal supervision.

Signed *Fred Wickerson*

Licensed Embalmer No. *7478*

P. O. Address *Cleburn 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.