

No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8328

National Office of Vital Statistics
FILED MAR 22 1948

Registration District No. 107

Primary Registration District No. 5395 4173

Registrar's No. 6

34
01

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

1. PLACE OF DEATH:

(a) County... Douglas

(b) City or town... Ava
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

3. (a) PRINT FULL NAME... Samuel J. Johnson

3. (b) If veteran, name war... No

3. (c) Social Security No. None

5. Color or race... White

6. (a) Single, widowed, married, divorced... Widowed

6. (b) Name of husband or wife...

6. (c) Age of husband or wife if alive... years

7. Birth date of deceased... September 14, 1864
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 83 | 4 | 14 | hr. min. |

9. Birthplace... Norway 4
(City, town, or county) (State or foreign country)

10. Usual occupation... Farming

11. Industry or business...

MOTHER: 12. Name... Johnson

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

14. Maiden name... Bertha

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

16. (a) Informant... Geo W Rollins

(b) Address... Ava, Mo

17. (a) Burial, cremation, or removal... Burial

(b) Date thereof... 1-30-48
(Month) (Day) (Year)

(c) Place: burial or cremation... Whites Creek

18. (a) Signature of funeral director... Clinkingbeard Funeral Home

(b) Address... Ava, Missouri

19. (a) 3-3-48 (Date received local registrar)

(b) West Bushman (Registrar's signature) 47

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... Douglas 34

(c) City or town... Ava 1
(If outside city or town limits, write "RURAL") 00

(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 Jan day 28, year 1948 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1st, 1948, to Jan 2nd, 1948, that I last saw him alive on Jan 2, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death... Heart failure

Due to... Pneumonia

Due to...

Other conditions... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations...

Of autopsy...

Underline the cause of 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? (Specify type of place)

While at work? (e) Manner of injury...

23. Signature... Date/signed... Feb 4, 1948

RECEIVED

District Health Officer No. 6,

District File Number 348-323

Date Filed MAR 17 1948

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. B. [Signature]*

Licensed Embalmer No. 3431

P. O. Address *Ans Md*

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.

Registration District No. 101

Primary Registration District No. 4473

1. PLACE OF DEATH:

(a) County Douglas

(b) City or town awa
(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 days)

3. (a) PRINT FULL NAME Samuel J 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: Sept 14 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) _____
(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 1948 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 heart failure Duration _____

Due to Procedural

Due to Pneumonia

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) (b) Means of injury _____

23. Signature Dr. J. H. Johnson (M. D. or other) _____
Date signed Apr 3, 1948

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

SUPPLEMENTARY

1948

S-8-128