

FILED SEP 7 1948

State File No.

Registration District No. 4

Primary Registration District No. 5023

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Atchison Co
(b) City or town Rock Port mo Rural
(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)
In this community most of life years, months or days

3. (a) PRINT FULL NAME SAMUEL KING 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 widowed

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

7. Birth date of deceased June 30 1862
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name David Johnson

13. Birthplace Vir. 1
(City, town, or county) (State or foreign country)

14. Maiden name Roxanna Smith

15. Birthplace Vir. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jake McCall

(b) Address Rock Port mo

17. (a) burial (b) Date thereof Aug 5 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Creek

18. (a) Signature of funeral director J. A. Watson

(b) Address Rock Port mo
19. (a) 8-4-48 (b) Betty Crabtree
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo- (b) County Atchison

(c) City or town Rural
(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 August day 3rd -
year 1948 hour 9⁰⁰ minute a- M.

21. I hereby certify that I attended the deceased from 1945
19 _____ to Aug 3 19 48
that I last saw him alive on July 25 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease

Due to _____

Due to _____

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

Major findings: 950

Of operations _____

Of autopsy _____

Duration

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 J. A. Watson (M. D. 0)

Address WATSON MO Date signed 8-3-48

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.....

B. E. Burton
.....
working under my personal supervision.

....., Registered Apprentice No.....

Signed *B. E. Burton*
.....

Licensed Embalmer No. *1764*

P. O. Address *Rock Port 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.

Registration District No. 4

Primary Registration District No. 5023

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Atchison
(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 K. 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 June 30
(Month) (Day) (Year)

8. AGE: Years 86 Months Days (If less than one day) hr. min. mo

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

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)

MOTHER FATHER

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Atchison
(c) City or town Rock Park (Rural)
(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 1948 year 1948 hour 11 minute 13 M.

21. I hereby certify that I attended the deceased from..... to....., 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?

(Specify type of place) While at work? (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

S-25358