

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. **3015**

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

1. PLACE OF DEATH:  
(a) County **Clinton**  
(b) City or town **Cameron**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Cameron Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 Day**  
In this community **Life**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Clinton**  
(c) City or town **Osborne**  
(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 **Jessie Earle Johnson**  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Dec** day **25**  
year **1948** hour **4** minutes **A.M.**  
21. I hereby certify that I attended the deceased from **Dec 1946**, 19\_\_\_\_ to **12-25-48**, 19\_\_\_\_  
that I last saw him alive on **12-29**, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Maude Johnson** 6. (c) Age of husband or wife if alive **55** years  
7. Birth date of deceased **June 2, 1888**  
(Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage**  
Duration **12 hrs**

8. AGE: Years **60** Months **6** Days **23**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace **Clinton Co., Mo.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Banker**

11. Industry or business \_\_\_\_\_  
12. Name **James Johnson**  
13. Birthplace **Kent, Mo.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Amitia Creamer**  
15. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
**g 30**

16. (a) Informant **Maude Johnson**  
(b) Address **Osborne Mo**  
17. (a) **Burial** (b) Date thereof **12 28 48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Osborne Mo**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Jesse Brown**  
(b) Address **Maysville, Mo.**  
19. (a) **12-27-48** (b) **Wimfred W. Moser**  
(Date received local registrar) (Registrar's signature) **390**

While at work? \_\_\_\_\_ (Specify type of place) Means of injury **0**  
23. Signature **John Kines** (M. D. or other) \_\_\_\_\_  
Address **Cameron, Mo.** Date signed **12-27-48**

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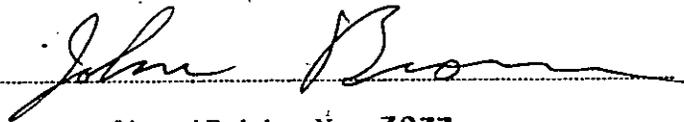
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**STATEMENT BY LICENSED EMBALMER**

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. 3933

P. O. Address Maysville 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.**