

S. No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39834

State File No. \_\_\_\_\_

FILED JAN 5 1949  
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1115

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:  
St Johns  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hours  
In this community Same as above (Specify whether years, months or days)

3: (a) PRINT FULL NAME Johnson, Infant

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased: December 25 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 0 0 2 hr. 0 min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name I H Johnson

13. Birthplace Sparta Unknown Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Fox Verano

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

16. (a) Informant I. H. Johnson

(b) Address Lebanon, Missouri

17. (a) Burial (b) Date thereof 12-25-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 12-28-48 (b) W J Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield  
(If outside city or town limits, write "RURAL")

(d) Street No. St Johns Hospital  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25th  
year 1948 hour 5 minute 35 A.M.

21. I hereby certify that I attended the deceased from Dec 25-1948 to Dec 25-1948  
that I last saw him alive on Dec 25-1948 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (28 wks)

Due to Premature Labor

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: None

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 I. L. Johnston (M.D. or other) \_\_\_\_\_  
Address Springfield, Mo Date signed 12/28/48

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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

*Jewell E. Kunkle*

Licensed Embalmer No. *2831*

P. O. Address *Springfield 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.**