

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4556**
Registrar's No. **145**

BIRTH NO. _____		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 2000		State File No. 4556		Registrar's No. 145			
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission). a. STATE Missouri b. COUNTY Greene							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield				c. LENGTH OF STAY (in this place) 17 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield					
d. FULL NAME OF HOSPITAL OR INSTITUTION O'Reilly VA Hospital				d. STREET ADDRESS (If rural, give location) 2209 Travis, Ave.,							
3. NAME OF DECEASED (Type or Print) a. (First) Lester			b. (Middle) J		c. (Last) Johnston			4. DATE OF DEATH (Month) (Day) (Year) 2 14 1949			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH November 28, 1893		9. AGE (In years last birthday) 55			
						IF UNDER 1 YEAR Months 2 Days 16		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Elkland, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Osla Johnston					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk		17. INFORMANT'S SIGNATURE OR NAME O'Reilly VA Hospital, Springfield, Mo.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 17 days	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalomalacia, pons							
				ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive arteriosclerotic heart disease						Unk.	
				DUE TO (c) Chronic Brights disease						Unk.	
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION 11200						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from January 29 1949 , to February 14 1949 , that I last saw the deceased alive on February 14 49 , and that death occurred at 7:20 Pm. , from the causes and on the date stated above.											
23. SIGNATURE Paul I. Eisele M.D.				(Degree or title)		23b. ADDRESS O'Reilly VAH, Springfield, Mo.		23c. DATE SIGNED 2/14/49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 2-16-49		24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo. ✓					
DATE REC'D BY LOCAL REG. 2-15-49		REGISTRAR'S SIGNATURE W E Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sorman Schupp		ADDRESS Springfield, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-489
2
4

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Lewis Schapiro

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3802

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.