

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8991

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BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY OR TOWN <u>Lexington Mo</u>		c. CITY OR TOWN <u>Lexington Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>South West Med. Center</u>		d. STREET ADDRESS <u>179 S. W Blvd</u>	
3. NAME OF DECEASED (Type or Print) <u>Albert J. Johnson</u>		4. DATE OF DEATH <u>Feb 27-1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>10-6-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mining</u>	11. BIRTHPLACE (State or foreign country) <u>Lexington Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Alfred Johnson</u>	
13b. MOTHER'S MAIDEN NAME <u>Mildred Larson</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Cleveland Wright</u> ADDRESS <u>Lex, Mo</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary embolism</u> ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Died suddenly sitting in chair</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Asthma H.D.C.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>no operatio</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	
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 <u>Called at County Coroner - 2-25-49</u> <u>at 1022</u> <u>that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.</u>	
23a. SIGNATURE (Degree or title) <u>W. Martin D. Coroner</u>		23b. ADDRESS <u>Lexington Mo</u>	
23c. DATE SIGNED <u>2-25-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>2-27-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maplelawn</u>	
24d. LOCATION (City, town, or county) (State) <u>Lexington Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Guep</u> ADDRESS <u>Lexington, Mo</u>	
DATE REC'D BY LOCAL REG. <u>Mar 2/29/49</u>		REGISTRAR'S SIGNATURE <u>Wm. E. ...</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8

District File Number.....

Date Filed 3-30-49

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 *J. L. McKean*

Signed.....
Student Embalmer

Licensed Embalmer No. 2983

P. O. Address.....

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.