

FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11183

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BIRTH NO. 48-31377 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give town) Sikeston	c. LENGTH OF STAY (In this place) 17 hrs	c. CITY (If outside corporate limits, write RURAL and give township) Matthews 72	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital		d. STREET ADDRESS (If rural, give location) R. # 1	

3. NAME OF DECEASED (Type or Print) a. (First) Judy	b. (Middle) Kay	c. (Last) Johnson	4. DATE OF DEATH (Month) (Day) (Year) Mar. 22 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 4-12-1948	9. AGE (In years last birthday) 11	IF UNDER 1 YEAR 11 Months 10 Days	IF UNDER 24 HRS. 1 Hour 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sikeston, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Harold Johnson	13b. MOTHER'S MAIDEN NAME Edith Farrenburg	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Harold Johnson, Father	ADDRESS R. # Matthews Mo
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Upper-Respiratory Infection. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 493X			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-19, 1949**, to **3-22, 1949**, that I last saw the deceased alive on **3-22, 1949**, and that death occurred at **5:25 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or title) Alden B. Sargent M.D.	23b. ADDRESS Sikeston, Mo	23c. DATE SIGNED 3-22-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/23/49	24c. NAME OF CEMETERY OR CREMATORY Evergreen	24d. LOCATION (City, town, or county) (State) New Madrid, Mo.
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DATE REC'D BY LOCAL REG. March 28 1949	REGISTRAR'S SIGNATURE Mrs. J.F. Henry 303	25. FUNERAL DIRECTOR'S SIGNATURE Richards Funeral Ser.	ADDRESS New Madrid Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 349-428

Date Filed 3-49-49

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 _____

Lawell Green Jr.

Student Embalmer No. 310

working under my personal supervision.

Signed Lawell Green Jr.
Student Embalmer

Signed L. H. Hepburn

Licensed Embalmer No. 3803

P. O. Address New Madrid, 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.