

FILED APR 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13073

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>199</u>		PRIMARY REG. DIST. NO. <u>2783</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural Walnut Township</u> )		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Walnut Township</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>South of Elmer Mo</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Archie</u>		b. (Middle) <u>F</u>		c. (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 10 1887</u>	
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas F. Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Malinda Turner</u>		14. NAME OF HUSBAND OR WIFE <u>Delilah Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>491-14-1619</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ralph W. Johnson Elmer 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>Epileptic Convulsions</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Influenza</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 days</u> <u>3533</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) <u>Elmer Macon Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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>April 17, 1949</u> , to <u>April 17, 1949</u> , that I last saw the deceased alive on <u>April 17, 1949</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. D. Schi D.D.</u> (Name or title)				23b. ADDRESS <u>Elmer Mo.</u>		23c. DATE SIGNED <u>4/18/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-20-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Elmer</u>		24d. LOCATION (City, town, or county) (State) <u>Elmer Macon County Mo</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 22 1949</u>		REGISTRAR'S SIGNATURE <u>Daphne Howerton</u> 184		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. &amp; Co.</u>		ADDRESS <u>South Gifford Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 3 1950

RECEIVED

District Health Officer N

District File Number <sup>4.42</sup>

APR 25 1949

D. L. F. L.

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

*Clyde W. Callum*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3226

P. O. Address South Gifford M. O.

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.