

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29672

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. B287 Registrar's No. 123

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

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs Rural</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>SARAH</u>	b. (Middle) <u>MELISSA</u>	c. (Last) <u>JOHNSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 15-1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED NEVER MARRIED; WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 23-1876</u>	9. AGE (In years last birthday) <u>73</u>	if UNDER 1 YEAR Months <u>2</u> Days <u>23</u>	if UNDER 4 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid 6 yrs</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House wife, Beau Leavenworth Co</u>	11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James P. Lynch</u>	13b. MOTHER'S MARDEN NAME <u>Sarah Cain</u>	14. NAME OF HUSBAND OR WIFE <u>Lucius O Johnson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edith Johnson, Ex. Spgs. Mo. R.I.</u>	ADDRESS <u></u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>?</u> <u>10 yrs</u> <u>5 yrs</u>	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rheumatic cardiac &amp; chronic auricular fibrillation</u>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Rheumatic fever</u> DUE TO (c) <u>&amp; Coronary sclerosis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Right Spemiplegia from cerebral embolus</u>			

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) <u>416X</u>
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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 December, 1947, to 15 Sept, 1949, that I last saw the deceased alive on 13 Sept, 1949, and that death occurred at 6:40 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. W. W. M. M.</u>	(Degree or title) <u>Mo.</u>	23b. ADDRESS <u>Liberty Mo.</u>	23c. DATE SIGNED <u>16 Sept 49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>	24b. DATE <u>Sept 17-49</u>	24c. NAME OF CEMETERY OR CREMATORY. <u>Walnut Grove</u>	24d. LOCATION (City, town, or county) (State) <u>Parkville Platt Mo.</u>
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DATE REC'D BY LOCAL REG. <u>9/15/49</u>	REGISTRAR'S SIGNATURE <u>Baroline D. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Fry</u>	ADDRESS <u>Kearney Mo</u>
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RECEIVED

OCT 6

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 10-6-49

**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.

Student \_\_\_\_\_

Student Embalmer

Signed \_\_\_\_\_

*Lennard J. J...*

Licensed Embalmer No. 1677

P. O. Address Keimoy 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.