

FILED JAN 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1812

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 4329 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wyatt		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wyatt	
c. LENGTH OF STAY (in this place) 17 yrs		d. STREET ADDRESS (If rural, give location) P. O. Box 113	
d. FULL NAME OF HOSPITAL OR INSTITUTION P. O. Box 113			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle)	c. (Last) Johnson	4. DATE OF DEATH (Month) (Day) (Year) Jan. 19, 1950
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 10, 1891	9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months 6 Days 9	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Quitman County, Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lula Mae Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lula Mae Johnson, P.O. Box 113, Wyatt, Mo.	18. ADDRESS _____
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		334X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 Jan 16, 1950, to Jan 19, 1950, that I last saw the deceased alive on Jan 19, 1950, and that death occurred at 11: A m., from the causes and on the date stated above.

23a. SIGNATURE T. P. Feunon (Degree or title) D.O.S.	23b. ADDRESS Wyatt, Mo.	23c. DATE SIGNED 1-23-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 22, 1950	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) Charleston, Missouri
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DATE REC'D BY LOCAL REG. Jan. 24, 1950	REGISTRAR'S SIGNATURE Mrs. L. H. Kilgore 439	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. J. Sparks Charleston, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

670

0670

6961 6707

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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau, 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.