

FILED MAR 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4086 State File No. 4177

BIRTH NO. _____ REG. DIST. NO. 387 PRIMARY REG. DIST. NO. 5240 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Carroll.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tina		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Stakes Mound. Town	
c. LENGTH OF STAY (in this place) 50 years		d. STREET ADDRESS (If rural, give location) Tina, Mo. 0170	
d. FULL NAME OF HOSPITAL OR INSTITUTION No.			

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) HENRY c. (Last) Johnson.			4. DATE OF DEATH (Month) (Day) (Year) Feb-16 1950		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	
8. DATE OF BIRTH Feb-7-1861		9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Days 09 IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME William Johnson		13b. MOTHER'S MAIDEN NAME Ms. Crocker	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Lemmie Johnson Tina Mo		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		19. INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4341	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 10 Feb, 1950 , to 16 Feb, 1950 , that I last saw the deceased alive on 16 Feb, 1950 , and that death occurred at 3:30 p.m. , from the causes and on the date stated above.		23a. SIGNATURE (Degree or title) Erroll Haven Allen MD	
23b. ADDRESS Tina		23c. DATE SIGNED 17 Feb 50		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE Feb-19-1950		24c. NAME OF CEMETERY OR CREMATORY Blue Mound		24d. LOCATION (City, town, or county) (State) Blue Mound, Mo.	
DATE REC'D BY LOCAL REG. Feb. 17, 1950		REGISTRAR'S SIGNATURE Mrs Rex Henderson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. A. Dickerson Bogard Mo	

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

RECEIVED FEB 26

District Health Officer No. 0

District File Number.

Date Filed 3-2-50

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 E. A. Dickerson

Licensed Embalmer No. 2534

P. O. Address Bozard, 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.