

FILED MAY 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15530

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 6087 Registrar's No. 22

970

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

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN R.F.D. Slater	c. LENGTH OF STAY (in this place) 87 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN R.F.D. Slater 970	
d. FULL NAME OF HOSPITAL OR INSTITUTION rural		d. STREET ADDRESS (If rural, give location) R.F.D.	

3. NAME OF DECEASED (Type or Print) a. (First) Elias b. (Middle) Washington c. (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) May 8 1950		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5/20/1863		9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 1 YEAR Hours IF UNDER 1 MIN. Min. 86 11 7	
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Saline County, Mo.		12. CITIZEN OF WHAT COUNTRY? U S	
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13a. FATHER'S NAME James Johnson		13b. MOTHER'S MAIDEN NAME Betsy		14. NAME OF HUSBAND OR WIFE Myrtle Johnson	
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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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Elias Johnson Slater--Mo.			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Coronary Disease		DUE TO (b) Hypertension					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						1501	

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 **March, 1950**, to **May, 1950**, that I last saw the deceased alive on **April 19, 1950**, and that death occurred at **5 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. C. Higgins M.D.		23b. ADDRESS Slater, Mo.		23c. DATE SIGNED 5-6-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 5/7/1950	24c. NAME OF CEMETERY OR CREMATORY Slater City		24d. LOCATION (City, town, or county) (State) Slater Mo.		
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DATE REC'D BY LOCAL REG. 5/8/50	REGISTRAR'S SIGNATURE Mrs. Earl C. Fritz		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Brothers Slater Mo.	
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RECEIVED MAY 1 1950
District Health Officer No. 8,

District File Number _____

Date Filed 5/12/50

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address St. Louis, 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.