

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30925

State File No.
Registrar's No. 72

FILED OCT 11 1950

BIRTH NO. 124 REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035

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

540

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) Lexington		c. CITY (If outside corporate limits, write RURAL and give township) Lexington	
c. LENGTH OF STAY (In this place) 10 days		d. STREET ADDRESS (If rural, give location) Maple Grove Park	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print) MINNIE JOHNSON			4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1950		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 5, 1882	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 11 Days 22	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	--------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Lexington, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	---	--

13a. FATHER'S NAME Ernest F. Schramm	13b. MOTHER'S MAIDEN NAME Elsie Muench	14. NAME OF HUSBAND OR WIFE Axel Johnson
---	---	---

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 Axel Johnson, Lexington, Mo.	ADDRESS
--	-------------------------------------	---	---------

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 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic myocarditis		33K	

19a. DATE OF OPERATION --	19b. MAJOR FINDINGS OF OPERATION	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) --	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 **Sept 17**, 19 **50**, to **Sept 27**, 19 **50**, that I last saw the deceased alive on **Sept 27**, 19 **50**, and that death occurred at **9:00 A.M.** from the causes and on the date stated above.

23a. SIGNATURE Ben H. B. Rasher M.D.	(Degree or title)	23b. ADDRESS Lexington, Missouri	23c. DATE SIGNED 9/27/50
---	-------------------	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/30/50	24c. NAME OF CEMETERY OR CREMATORY Maahpalah	24d. LOCATION (City, town, or county) (State) Lexington, Mo.
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. Oct. 9, 1950	REGISTRAR'S SIGNATURE Theresa E. Eastwood	25. FUNERAL DIRECTOR'S SIGNATURE James P. Kempel	ADDRESS Bel. Mo
--	--	---	------------------------

RECEIVED 10-10-50

Presit

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 10-10-50 _____

09612 T 100

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed *Geo. McKean*

Signed _____
Student Embalmer

Licensed Embalmer No. *2983*

P. O. Address *Livingston 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.