

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Sewell
State File No. **24177**
Registrar's No. **708**

FILED AUG 4 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

5396
0

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WILLOW SPRINGS	
c. LENGTH OF STAY (In this place) 10 da		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) CRAWFORD	b. (Middle) JOHN	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) JULY 27, 1952
-------------------------------------	----------------------------	-------------------------	--------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 4, 1887	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Hours	IF UNDER 1 MIN. Min.
--------------------	-------------------------------	---	--------------------------------------	---	------------------------	-----------------------	----------------------

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

13a. FATHER'S NAME William Johnson	13b. MOTHER'S MAIDEN NAME Louisa Collins	14. NAME OF HUSBAND OR WIFE Florence Collins 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. 487-18-2445	17. INFORMANT'S SIGNATURE OR NAME Mrs Florence Johnson, Willow Springs	ADDRESS
--	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Dilatation of Heart		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Following Prosthetic Prostheses Super aortic.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral hemorrhage few months previous.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Benign Hypertrophy of Prostate Gland.	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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 610 X
--	--	---

22. I, hereby certify that I attended the deceased from **7-17, 1952** to **7-27, 1952** that I last saw the deceased alive on **7-26, 1952** and that death occurred at **5:40 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Walter Sewell (Degree or title)	23b. ADDRESS 608 Cherry Street	23c. DATE SIGNED 7-28-52
---	---------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/27/52	24c. NAME OF CEMETERY OR CREMATORY Little Zion, Douglas Co.,	24d. LOCATION (City, town, or county) (State) WILLOW SPRINGS, MO.
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. 7-29-52	REGISTRAR'S SIGNATURE Edith Williamson (County) Regist.	25. FUNERAL DIRECTOR'S SIGNATURE HERMAN H. LOHMEYER, ADDRESS SPRINGFIELD
---	---	--

VS JUL 11 1960

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 *H. L. McCarver*

Signed.....
Student Embalmer

Licensed Embalmer No. 2727

P. O. Address Springfield 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.