

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2129

FILED JAN 29 1953

BIRTH NO. REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3039 Registrar's No. 530

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>505 E. Crocker</u>		d. STREET ADDRESS (If rural, give location) <u>505 E. Crocker</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Andrew</u> b. (Middle) <u>Wilhite</u> c. (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 19, 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1871</u>
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>--</u> Min. <u>--</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Andrew Wilhite Johnson</u>	
13b. MOTHER'S MAIDEN NAME <u>Ester Wheeler</u>		14. NAME OF HUSBAND OR WIFE <u>Lydia Smith Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lydia Johnson, Marceline, Mo.</u>
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ARTERIO SCLEROSIS, GENERALIZED</u> ANTECEDENT CAUSES <u>ARTERIOSCLEROTIC HEART DISEASE</u> 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. <u>DEHYDRATION, INANITION</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4200</u>	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) m.	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 <u>JULY 1952</u> to <u>JAN 1953</u> , that I last saw the deceased alive on <u>JAN 19, 1953</u> , and that death occurred at <u>6:45 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Paul T. Berry MD</u> (Degree or title)		23b. ADDRESS <u>Marceline, Mo.</u>	23c. DATE SIGNED <u>1-20-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 21, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hull Cemetery</u>	24d. LOCATION (City, town, or county) (State). <u>North of Callao, Mo.</u>
DATE REC'D BY LOCAL REG. <u>1-20-53</u>	REGISTRAR'S SIGNATURE <u>Maryanne Owens</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hillman</u> ADDRESS <u>New Columbia Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

581
1

FEB 17 1954

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 _____

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.