

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4438**

FILED FEB 9 1953

BIRTH NO. _____ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3672** Registrar's No. **28**

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 Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stater 0971	
c. LENGTH OF STAY (in this place) 4 days		d. STREET ADDRESS (If rural, give location) Central St. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Robney b. (Middle) Charles c. (Last) Johnson			4. DATE OF DEATH (Month) (Day) (Year) 1-30-1953		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED 0	8. DATE OF BIRTH 1-27-1953		9. AGE (In years last birthday) 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Marshall Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Morris Johnson		13b. MOTHER'S MAIDEN NAME Marline Melon	

14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME Homer Gilliam		ADDRESS Miami Mo			

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) _____		Pneumonia-bronchial			10 hrs.
*This does not mean the mode of dying, such as heart failure, atherosclerosis, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
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.			7630

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 **1-27, 1953**, to **1-31, 1953**, that I last saw the deceased alive on **1-30, 1953**, and that death occurred at **2:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE P. A. McEuney (Degree or title)		23b. ADDRESS Stater Mo.		23c. DATE SIGNED 1/31/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-31-53		24c. NAME OF CEMETERY OR CREMATORY Stater City Cemetery	
24d. LOCATION (City, town, or county) Stater		24e. (State) Mo			
DATE REC'D BY LOCAL REG. 1-31-1953		REGISTRAR'S SIGNATURE Friday 5 Gray 385-1		25. FUNERAL DIRECTOR'S SIGNATURE Hill Bros ADDRESS Stater Mo	

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

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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 ^{not} _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Sam M Hill _____

Licensed Embalmer No. 1292 _____

P. O. Address _____

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.