

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. MARSHALL

31502

State File No.

FILED OCT 13 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 200 Registrar's No. 931

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		d. STREET ADDRESS (If rural, give location) 715 E. MADISON	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES	b. (Middle) L.	c. (Last) JOHNSON	4. DATE OF DEATH (Month) (Day) (Year) OCT. 3, 1953
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 30 1888	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 4 HRS. Hours	IF UNDER 15 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPTOMETRIST	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) OZARK, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ZACKARIAH JOHNSON	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE X
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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. NO	17. INFORMANT'S SIGNATURE OR NAME JAMES JOHNSON ADDRESS BALDWIN, KANSAS
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) Thrombosis of cerebral vessel DUE TO (c) Generalized arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) (Min.)	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 6-12, 1953, to 10-3, 1953, that I last saw the deceased alive on 10-3, 1953, and that death occurred at 10:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James C. Marshall, M.D.	23b. ADDRESS Professional Bldg.	23c. DATE SIGNED 10-5-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 10.6/53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) NEW LONDON, MO.
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DATE REC'D BY LOCAL REG. 10-5-53	REGISTRAR'S SIGNATURE Emilia Williams	25. FUNERAL DIRECTOR'S SIGNATURE H. H. LOHMEYER ADDRESS SPRINGFIELD, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 27 1953

OCT 28 1953

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 *Lucian J. Swadlow*

Licensed Embalmer No. *4875*

P. O. Address *Springfield*

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.