No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 17 1955

State File No. 34385

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO 3056 Registrar's No. 246

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
c. LENGTH OF STAY (in this place): 16 da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodland Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Monroe
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Madison
d. STREET ADDRESS (If rural, give location): rural

c690

3. NAME OF DECEASED (Type or Print)
a. (First): Jacob
b. (Middle): Meade
c. (Last): Johnston

4. DATE OF DEATH (Month) (Day) (Year): Oct 7 1955

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, ~~NEVER MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Specify): married
8. DATE OF BIRTH: Oct 4 1865
9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Madison, Mo (CR)
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Jacob Johnston
13b. MOTHER'S MAIDEN NAME: Amanda Hendrix
14. NAME OF HUSBAND OR WIFE: Willie Tom Walters

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: Mrs Cecil Gaines
ADDRESS: Madison Mo RR

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension Cardiovascular Dis — ?
DUE TO (c): 443X

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 ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 30, 1955, *to* Oct 7, 1955, *that I last saw the deceased alive on* Oct 5, 1955, *and that death occurred at* 12 30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: Moberly Mo
23c. DATE SIGNED: Oct 8 55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 9/1955
24c. NAME OF CEMETERY OR CREMATORY: Sunset Hill
24d. LOCATION (City, town, or county) (State): Madison Mo

DATE REC'D BY LOCAL REG.: Oct 9-55
REGISTRAR'S SIGNATURE: [signature] 269-0
25. FUNERAL DIRECTOR'S SIGNATURE: Fred A Thompson
ADDRESS: Madison Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 Paul G. Thompson

Signed.....
Student Embalmer

Licensed Embalmer No. 1420

P. O. Address Madison, W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w/ the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.