FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1908
STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY LINN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BROOKFIELD — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 401 BEVERLY ST — Length of stay in lb 70 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY LINN
c. CITY OR TOWN BROOKFIELD 0582 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 401 BEVERLY ST — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First ELLA Middle - Last JOHNSON
4. DATE OF DEATH Month Day Year JAN. 9, 1957
5. SEX F 3
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH NOV. 15, 1881
9. AGE (In years last birthday) 75 — 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) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (City and state or country) LACLEDE, MO 0
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME WILLIAM LEWIS
14. MOTHER'S MAIDEN NAME MARTHA. —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address GEO. E. JOHNSON, BROOKFIELD, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — Unknown.
DUE TO (c) Senility.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5-16-56, to 1-9-57 and last saw her/him alive on 1-9-57
Death occurred at 10 30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) K. W. Bohnsack M.D. 0
22b. ADDRESS Brookfield Mo.
22c. DATE SIGNED 1/10/57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE JAN. 13, 1957
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL
23d. LOCATION (City, town, or county) (State) BROOKFIELD, MO

24. FUNERAL DIRECTOR ADDRESS WRIGHT FUNERAL HOME, BROOKFIELD
25. DATE RECD. BY LOCAL REG. 1-12-57
26. REGISTRAR'S SIGNATURE Katharine Johnson Dep.

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

57-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 371

P. O. Address Brookfiel

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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