

FILED APR 22 1957

STANDARD CERTIFICATE OF DEATH

15880

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. #6093 Registrar's No. 66Health,
& Welfare
Public
ServiceS. 300
v. 1-56securing the medical certification in the specific manner required by 193-140 W.S. 1949.
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

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, give TOWNSHIP only) OR TOWN Marshall		c. CITY OR TOWN Marshall	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Home		d. STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or print) Amos Ford Johnson		4. DATE OF DEATH April 14-'57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 8th 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Disabled		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saline Co. Mo.
13. FATHER'S NAME Joe M. Johnson		14. MOTHER'S MAIDEN NAME Elizabeth Chandler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 709-12-3199	17. INFORMANT Mrs. Ira Johnson Slater
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 hemorrhage Conditions, if any, which gave rise to above cause: (a) } DUE TO (b) Hypertension stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6-11-1950
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION Marshall Mo.	
21. I attended the deceased from Oct. 1956 , to April 13th 57 and last saw deceased on April 13th 57 . Death occurred at 2 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE P. L. Lawless M.D.		22b. ADDRESS Marshall Mo.	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial		23b. DATE Apr. 15-'57	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Slater, Mo.	
24. FUNERAL DIRECTOR Hill Brothers		25. DATE RECD. BY LOCAL REG. 4-15-57	
ADDRESS Slater mo.		26. REGISTRAR'S SIGNATURE Cecil H. Read	

(Licensed Embolmer's Statement on Reverse Side)

529
0

APR 29 1957

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.....
Signature of Student Embalmer

Signed..... *R. C. Hill*

Licensed Embalmer No. *3090*

P. O. Address *State*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.