FILED JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28023
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 743

1. PLACE OF DEATH
a. COUNTY Green County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield mo — Inside Limits Yes X No
c. FULL NAME OF HOSPITAL OR INSTITUTION 1936 Rockisland Springfield Mo — Length of stay in Ib 6 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Green
c. CITY OR TOWN Springfield Mo — Inside Limits Yes X No
d. STREET ADDRESS (If outside, give location) 1936 Rockisland — Reside on Farm Yes No X

3. NAME OF DECEASED (Type or print): First William Middle Marion Last Johnson
4. DATE OF DEATH Month July Day 22 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED NEVER MARRIED WIDOWED X DIVORCED
8. DATE OF BIRTH Sept 23-1862
9. AGE (In years last birthday) 94 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Mo. Christian County
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Jehu Johnson
14. MOTHER'S MAIDEN NAME Nancy Boals
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Mrs Dewey Ladd. Address 1936 Rockisland Springfield 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) Anemia, Secondary
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Enteritis, type Unknown
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Malnutrition. Ageing
19. WAS AUTOPSY PERFORMED? YES NO ✓
UNATTENDED BY A PHYSICIAN
5711

20a. ACCIDENT SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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~~ _____ to _____ ~~and last saw her/him alive on~~ _____
Death occurred at 2:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James R Cross M.D. (Degree or Title) Health Officer
22b. ADDRESS Greene County Health Dept Springfield, Missouri
22c. DATE SIGNED 8/16/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7-23-57
23c. NAME OF CEMETERY OR CREMATORY Sparta Cemetry
23d. LOCATION (City, town, or county) (State) Christian Co. Mo

24. FUNERAL DIRECTOR T. B. Chaffin & Son Inc. ADDRESS
25. DATE RECD. BY LOCAL REG. 7-25-57
26. REGISTRAR'S SIGNATURE Edith Williams

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes. diseases in Part I must be casually related.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed....T. B. Chaffin.....

Licensed Embalmer No. 21

P. O. Address ..Ozark..

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.