

Health,
& Welfare
Public
Service

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30821
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 319

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Paris</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. med. Center</u>		Length of stay in lb <u>150 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Johnson</u> Last <u>Mitchell</u>			4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>57</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1893</u>	9. AGE (In years last birthday) <u>64</u>	10. UNDER 1 YEAR Months <u>6</u> Days <u>14</u>	11. UNDER 24 HRS. Hours <u>64</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Monroe, County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>F. David Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Carrie Randall</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>496-22-7825</u>	17. INFORMANT <u>Hospital chart</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> Interval between ONSET AND DEATH <u>1 min</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Probable mural thrombus from recent Myocardial Infarction</u> 1 day DUE TO (c) <u>Arteriosclerotic Heart Disease</u> 4200 Interval between ONSET AND DEATH <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus, Old Pulmonary Infarction probable</u>		

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.)
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20c. TIME OF INJURY Hour <u>4:20</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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 <u>Paris, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>9-3-57</u> to <u>9-9-57</u> and last saw ^{her} _{him} alive on <u>9-9-57</u> Death occurred at <u>4:20</u> <u>P.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Diane Burkhardt, M.D.</u>	22b. ADDRESS <u>Missouri U. Medical Center</u>	22c. DATE SIGNED <u>9-9-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-11-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Paris, Mo.</u>
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24. FUNERAL DIRECTOR <u>E. B. Agnew</u>	ADDRESS <u>Paris, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 10 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R. E. Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *E. H. Agnew*

Licensed Embalmer No. *4000*

P. O. Address *Paris, Mo.*

**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.**