

Health,  
& Welfare  
S. Public  
th Service

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

393370  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 5030 Registrar's No. 1226

S. 300  
v. 1-57

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death.)<br>a. STATE Missouri b. COUNTY Buchanan |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township          |  | c. CITY OR TOWN St. Joseph   |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 1112 E. Joseph St. |  | d. STREET ADDRESS (If outside, give location) 1112 E. Joseph   |  |
| Length of stay in 1b 8 years   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Rebecca Johnson |  |  | 4. DATE OF DEATH<br>Month Day Year<br>Nov. 8, 1957 |  |  |
|---|--|--|--|--|--|

|                  |                           |   |                                   |                                    |                              |                                |
|------------------|---------------------------|---|-----------------------------------|------------------------------------|------------------------------|--------------------------------|
| 5. SEX<br>Female | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Dec. 29, 1884 | 9. AGE (In years last birthday) 72 | FUNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|------------------|---------------------------|---|-----------------------------------|------------------------------------|------------------------------|--------------------------------|

|  |   |   |  |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife | 10b. KIND OF BUSINESS OR INDUSTRY<br>own home | 11. BIRTHPLACE (City and state or country)<br>Christian County, Mo. | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
|--|---|---|--|

|                                     |   |  |
|-------------------------------------|---|--|
| 13a. FATHER'S NAME<br>Joseph Hughes | 13b. MOTHER'S MAIDEN NAME<br>Elizabeth Burkhart | 14. NAME OF HUSBAND OR WIFE<br>J. A. Johnson |
|-------------------------------------|---|--|

|   |                                 |  |
|---|---------------------------------|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no | 16. SOCIAL SECURITY NO.<br>none | 17. INFORMANT Address<br>Mrs. A. L. Bougher 1122 E. Joseph St. |
|---|---------------------------------|--|

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>arteriosclerotic Heart disease</u>             |  |   |
| DUE TO (c) _____   |  | _____   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>4200</u>           |  |   |

|  |
|--|
| 19. WAS AUTOPSY PERFORMED? <u>2</u><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|

|   |   |
|---|---|
| 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.)<br><u>4200</u> |
|---|---|

|   |
|---|
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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 COUNTY STATE |
|---|--|---|

|  |
|--|
| 21. I attended the deceased from <u>Oct 21, 1957</u> to <u>Nov. 8 - 1957</u> and last saw <sup>her</sup> alive on <u>Oct 21, 1957</u><br>Death occurred at <u>11:00 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
|--|

|  |   |                                    |
|--|---|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><u>Martin H. Christ MD</u> | 22b. ADDRESS<br><u>6166 King Hill ave</u> | 22c. DATE SIGNED<br><u>11-7-57</u> |
|--|---|------------------------------------|

|  |                                 |   |   |
|--|---------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Nov. 11, 57</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park Cem.</u> | 23d. LOCATION (City, town, or county) (State)<br><u>St. Joseph, Mo.</u> |
|--|---------------------------------|---|---|

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 24. FUNERAL DIRECTOR<br><u>Clark Funeral Home</u> | ADDRESS<br><u>St. Joseph, Mo</u> | 25. DATE RECD. BY LOCAL REG.<br><u>Nov 15, 1957</u> | 26. REGISTRAR'S SIGNATURE<br><u>Mrs Robert Fulton</u> |
|---|----------------------------------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

48

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 *Emil A. Clark* .....

Licensed Embalmer No. *4235* .....

P. O. Address *St. Joseph* .....

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.