

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40965

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 118

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Lexington</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>Lexington Memorial Hospital 2 wks</u> | | | | Length of stay in lb | | d. STREET ADDRESS (If outside, give location) <u>Maple Grove Park</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>WILLIAM</u> Last <u>JOHNSON</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 18, 1886</u> | |
| 9. AGE (In years last birthday) <u>71</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>employee</u> | | 11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Alfred Johnson</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Matilda Larson</u> | | | | 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>none</u> | | | | 17. INFORMANT <u>Mrs G.C. Wright, Lexington, Mo.</u> | | | |
| 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>Cerebral thrombosis</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 da.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? 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.) | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | | | | | |
| 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 | | COUNTY STATE | |
| 21. I attended the deceased from <u>Nov. 4/57</u> to <u>Nov. 8/57</u> and last saw <u>him</u> alive on <u>Nov 7, 1957</u> . Death occurred at <u>3745 1st St</u> in on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Typed or title) <u>Ralph W. Kelly M.D.</u> | | | | 22b. ADDRESS <u>Lexington, Mo.</u> | | 22c. DATE SIGNED <u>11/25/57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>November 10 1957</u> | | <u>Memorial Park</u> | | <u>Lexington, Missouri.</u> | |
| 24. FUNERAL DIRECTOR <u>Foster H. Tennel, Lexington, Missouri</u> | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>12-6-57</u> | | 26. REGISTRAR'S SIGNATURE <u>William E. Eastbrook</u> | |

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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.

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..... *L. S. McLean*

Licensed Embalmer No. *298*

P. O. Address *Trinity, Miss*

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.