

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

44063  
STATE FILE NUMBER  
2000 Registrar's No. 1212

FILED DEC 23 1957

Registration District No. 120 Primary Registration District No.

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Springfield</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Caulfield</b> <b>0469</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>OZARK OSTEOPATHIC HOSPITAL</b> HOSPITAL OR INSTITUTION Length of stay in 1b		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle Last <b>JOHNS</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16 1888</b>	9. AGE (In years less birthday) <b>69</b>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Sullivan County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Andrew Johns</b>	13b. MOTHER'S MAIDEN NAME <b>Addie Kinner</b>	14. NAME OF HUSBAND OR WIFE <b>Ivey Johns</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>Mrs. Ivey Johns Caulfield, Mo.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Acute Congestive Heart failure</b> DUE TO (c) <b>Possible C.A. of vessels</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b> <b>7 days</b> <b>7 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>178X</b>		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 Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **10:45 p.m.** \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Andrew Martinek, D.O.</b>	22b. ADDRESS <b>Springfield Mo</b>	22c. DATE SIGNED <b>12-18-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/19/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Scobbie Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Pollock, Mo.</b>
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24. FUNERAL DIRECTOR <b>Robertson Funeral Home West Pains, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-20-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b> <b>K.S.</b>
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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

Security of medical certification in this specific manner required by P.S. 1929 MO.R.S. 1949.

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 .....<sup>rust</sup> Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed H L Mc Carr.....

Licensed Embalmer No. 2727.....  
P. O. Address Springfield.....

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.