

FILED MAR 25 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011225

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4457 Registrar's No. 17

300
-57

930
0

1. PLACE OF DEATH a. COUNTY <u>ST CLAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST CLAIR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OSCEOLA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>OSCEOLA</u> <u>0930</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>OSCEOLA HOSP</u>		Length of stay in 1b <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>DOYAL TWP</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edwin</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>MAR</u> Day <u>7</u> Year <u>1958</u>		
--------------------------------------------------------------------------------------------------	--	--	--------------------------------------------------------------------	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1870</u>	9. AGE (In years last birthday) <u>87</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. Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------	----------------------------------------------	-------------------------------------------------------------------------------	--------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>SWEDEN</u>	12. CITIZEN OF WHAT COUNTRY? <u>Europe</u>
---------------------------------------------------------------------------------------------------------------	-----------------------------------	-------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Anne Johnson</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>Anne Johnson</u>	Address <u>OSCEOLA 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>General metastatic malignancy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>primarily probably in prostate</u> DUE TO (c) <u>177X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9</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 <u>11:00</u> a.m. <u>0</u> p.m. <u>0</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>OSCEOLA</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
----------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	------------------------------------------------	---------------------	--------------------

21. I attended the deceased from <u>July 5 58</u> to <u>3-7 58</u> and last saw ^{her} him alive on <u>3-7-58</u> Death occurred at <u>4:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ruth Seewers MD</u> (Degree or title)	22b. ADDRESS <u>OSCEOLA MO</u>	22c. DATE SIGNED <u>3-10-58</u>
------------------------------------------------------------	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-10-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OSCEOLA Catholic</u>	23d. LOCATION (City, town, or county) (State) <u>OSCEOLA MO</u>
------------------------------------------------------------	-----------------------------	---------------------------------------------------------------	--------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>General Home Osceola MO</u>	ADDRESS <u>OSCEOLA MO</u>	25. DATE RECD. BY LOCAL REG. <u>3-10-58</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seewers</u>
--------------------------------------------------------	------------------------------	------------------------------------------------	--------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. B. Daniels*

Licensed Embalmer No. *3038*

P. O. Address *Osceola, Va*

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.