

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013845

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 397

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Spgfld. Bap. Hosp.</u>		Length of stay in lb <u>16 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>801 W. Division</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>L.</u> Last <u>Johnson</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1958</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>Aug. 19, 1982</u>	9. AGE (In years last birthday) <u>75</u>	10. FUNDER YEAR Months <u>7</u> Days <u>15</u>	11. IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Potter, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>William Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Effie Johnson</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>Unknown</u>	17. INFORMANT <u>Rev. Robert Johnson-Springfield, Mo.</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>Cerebral Artery Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		332X
DUE TO (c) _____		
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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 _____
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21. I attended the deceased from Death occurred at <u>Sept 57</u> to <u>April 12 '58</u> and last saw him on <u>April 12 '58</u> <u>8:00 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>James T. Good, M.D.</u> (Degree or title)	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>4-15-58</u>
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23a. BURIAL, CREMATION, REPOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-14-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>James</u> ADDRESS <u>Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-16-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

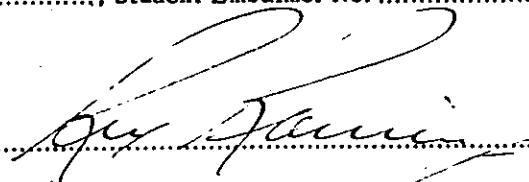
MEDICAL CERTIFICATION

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  -----

Licensed Embalmer No. 3312 -----

P. O. Address Springfield, 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.