

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000891

STATE FILE NUMBER

FILED JAN 27 1959 Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 7

300 #
1-57

1. PLACE OF DEATH a. COUNTY GASCONADE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY ASAGE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROARK TWP.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN FREDERICKSBURG
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL FRENE VALLEY HOME		Length of stay in lb 5 weeks	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES GARFIELD Johnson			4. DATE OF DEATH Month Day Year JAN 13-1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 10-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FERRYMAN		10b. KIND OF BUSINESS OR INDUSTRY RIVER FERRY	9. AGE (In years last birthday) 77
11. BIRTHPLACE (City and state or country) FREDERICKSBURG Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME FRANK JOHNSON		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE THYRA JOHNSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Mrs Russell Eberlin Hermann Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Epidermoid DUE TO (b) Carcinoma of floor of mouth Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 143X			INTERVAL BETWEEN ONSET AND DEATH 2 years
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. Month, Day, Year 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 Jan. 1955 to Jan. 1959 and last saw ^{him} alive on 1/13/59 Death occurred at 8:37 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W. A. Jeter, M.D.		22b. ADDRESS Hermann, Missouri	22c. DATE SIGNED 1/14/59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/17/59	23c. NAME OF CEMETERY OR CREMATORY ST. PETER'S CEMETERY	23d. LOCATION (City, town, or county) (State) R70 MORRISON Mo
24. FUNERAL DIRECTOR HUGO H. BLUMER		ADDRESS HERMANN Mo	25. DATE RECD. BY LOCAL REG. 1-16-59
26. REGISTRAR'S SIGNATURE Helma Giffelman			

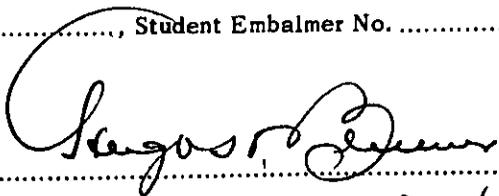
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

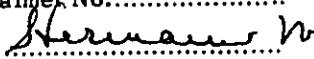
All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 3160
P. O. Address 

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.