Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004880
STATE FILE NUMBER

FILED FEB 26 1959

Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 26

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Liberty — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): IOOF Hospital — Length of stay in 1b: 3 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Carroll
c. CITY OR TOWN: Carrollton 0171 c — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Hilton Last: Johnson

4. DATE OF DEATH: Month Feb. Day 15 Year 1959

5. SEX: male 0

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 4, 1896

9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired mail carrier

10b. KIND OF BUSINESS OR INDUSTRY: US Govt

11. BIRTHPLACE (City and state or country): Carrollton, Missouri 0

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Robert Johnson, Sr.

13b. MOTHER'S MAIDEN NAME: Sarah C. (Unknown)

14. NAME OF HUSBAND OR WIFE: --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: T. E. Weaver — Address: Liberty, Missouri

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 4 Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 157X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 28, to ____ and last saw her/him alive on Feb 15, 1959
Death occurred at 9 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. M. Goodson M.D.

22b. ADDRESS: Liberty MO

22c. DATE SIGNED: 2/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 2-17-59

23c. NAME OF CEMETERY OR CREMATORY: Oakhill Cemetery

23d. LOCATION (City, town, or county) (State): Carrollton, Missouri

24. FUNERAL DIRECTOR — ADDRESS: Marshall Funeral Home Carrollton Missouri

25. DATE RECD. BY LOCAL REG.: 2-21-59

26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

FEB
CL
HEALT

MAR 3 1959

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 4534

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.