

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006357  
STATE FILE NUMBER

FEB 25 1959

Registration District No. 200 Primary Registration District No. \_\_\_\_\_ Registrar's No. 32

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Callao</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Callao 1610</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		Length of stay in 1b _____	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>JAMES F. JOHNSON</u>			<u>2</u>	<u>2</u>	<u>59</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-87</u>		9. AGE (In years last birthday) <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Callao Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>James Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth C. Perkins</u>		14. NAME OF HUSBAND OR WIFE _____	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Paul Johnson</u>	Address <u>Callao Mo</u>
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18. CAUSE OF DEATH (Write only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		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 _____ a.m. _____ p.m. _____		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <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 <u>Callao Mo</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>June 15, 58</u> to <u>Feb 2, 59</u> and last saw <u>him</u> alive on <u>Feb 1, 59</u> Death occurred at <u>1015 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>C E Sharp D.O.</u>		22b. ADDRESS <u>Callao Mo</u>		22c. DATE SIGNED <u>2/16/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-4-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Callao Cemetery</u>	23d. LOCATION (City, town, or county) <u>Callao Mo</u>	(State) <u>Mo</u>
24. FUNERAL DIRECTOR <u>H. S. Edwards</u>		ADDRESS <u>Callao Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2/19/59</u>	26. REGISTRAR'S SIGNATURE <u>Paul M Keely</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification: Part I must be completed in near 10-15 minutes. All diseases in Part I must be causally related.

Date Filed ..... 2 - 24 - 59

FEB 25 1959

(P.F.)

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 *H. S. Edwards* .....

Licensed Embalmer No. *1961* .....  
P. O. Address *Bavies* .....

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.