

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010642

STATE FILE NUMBER

FILED APR 15 1959

Registration District No. 316 Primary Registration District No. Registrar's No. 129

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> COUNTY <u>St Francois</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Frankclay</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Frankclay</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 lb <u>60</u> Years	d. STREET ADDRESS (If outside, give location) <u>None</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Everett</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1959</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>July 6, 1898</u>		9. AGE (In years last birthday) <u>60</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Potosi, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Perry Johnson</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Owens</u>			14. NAME OF HUSBAND OR WIFE <u>Lorene Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, or unknown) (If type, give war or dates of service) <u>Yes WI</u>			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Wife-Lorene Johnson, Frankclay, 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>Nephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>and Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Not Known</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>446X</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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Dec 3 1959</u> to <u>4/3/59</u> and last saw ^{her} him alive on <u>4/1/59</u> Death occurred at <u>545 A m</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John W. Hunt</u> (Degree or title) <u>J.M.D.</u>				22b. ADDRESS <u>Leadwood Mo</u>			22c. DATE SIGNED <u>4/4/59</u>		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>April 5, 1959</u>		<u>Adams Cemetery</u>		<u>Frankclay, Missouri</u>			
24. FUNERAL DIRECTOR <u>Bert L Boyer</u> <u>Leadwood, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Apr. 8, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 1930

STATEMENT BY LICENSED EMBALMER

JAN 4 1930

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 *Edw. L. Bryan*

Licensed Embalmer No. 3445

P. O. Address *Leedswood*

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.