

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018637
STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 194

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Pettis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Pettis</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Sedalia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Sedalia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1721 So. Sneed</i>		Length of stay in 1b <i>34 yrs</i>		d. STREET ADDRESS (If outside, give location) <i>1617 So. Carr</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Wilmett</i> Middle <i>Lee</i> Last <i>Johnson</i>				4. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 3 1895</i>		9. AGE (In years last birthday) <i>63</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (City and state or country) <i>Sonia Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13a. FATHER'S NAME <i>William H. Mason</i>		13b. MOTHER'S MAIDEN NAME <i>Amanda L. Carpenter</i>		14. NAME OF HUSBAND OR WIFE <i>Manfred Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs Betty Landon</i>		Address <i>1721 S. Sneed Sedalia</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Neuro-fibro-sarcoma Retroperitoneal</i> DUE TO (b) <i>Unknown</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
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. Month, Day, Year _____							
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 <i>March 19, 59</i> to <i>May 29, 59</i> and last saw her/him alive on <i>May 28, 1959</i> Death occurred at <i>2:45 a.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>John E. Harvey M.D.</i>				22b. ADDRESS <i>1609 So. Limit Sedalia Mo</i>		22c. DATE SIGNED <i>5/29/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6-1-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>Sedalia Mo</i>		
24. FUNERAL DIRECTOR <i>McLaughlin Bros Sedalia</i>			25. DATE RECD. BY LOCAL REG. <i>June 2 1959</i>		26. REGISTRAR'S SIGNATURE <i>Fredrick Shelby</i>		

AUG 28 1959

VS
JUN 22 1960
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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 *KPM Leary*

Licensed Embalmer No. *3153*

P. O. Address *Sedalia 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.