

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025871

FILED VS JUL 29 1959

Registration District No. 87 Primary Registration District No. 3040 Registrar's No. 191

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>	Length of stay in 1b <u>2 Mos</u>	c. CITY OR TOWN <u>Chillicothe</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 <u>147 Stewart St.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>147 Stewart St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>DEBBIE LORRAINE JOHNSON</u>	4. DATE OF DEATH Month Day Year <u>July 20, 1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>INFANT</u>	8. DATE OF BIRTH <u>5/1/59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>2</u> Days _____ Hours _____ Min. _____ IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>	11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Hatfield</u>	14. NAME OF HUSBAND OR WIFE <u>INFANT</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>147 Stewart St. Robert Johnson Chillicothe, Missouri</u>
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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>Pneumonia, Bronchial bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT 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 COUNTY STATE
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21. I attended the deceased from None, to and last saw her alive on July 20 1959
Death occurred at Seven Fifteen A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>Joseph G. Conrad M.D. (Coroner)</u>	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>July 21 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Missouri</u>
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24. FUNERAL DIRECTOR <u>NORMAN FUNERAL HOME</u>	ADDRESS <u>Chillicothe, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>7/21/59</u>	26. REGISTRAR'S SIGNATURE <u>Francois B Neill</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Bolin

Licensed Embalmer No. 5035

P. O. Address Chillicothe, I

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.