

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

83
59-029660

STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 202699

IDED

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>21 West Springfield St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Aurora</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>21 West Springfield St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>L.</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</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>10-5-1882</u>		9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Harry Co. Mo.</u>				11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Q. A. Johnson</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Teague</u>				14. NAME OF HUSBAND OR WIFE <u>Rose Johnson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Rose Johnson 21 W. Springfield St.</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>Large stroke blood clotted.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Years (3)</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic coronary thrombosis.</u>										<u>Years -</u>					
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					
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. Month, Day, Year _____															
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1956</u> to <u>April 24, 1959</u> and last saw him alive on <u>April 24, 1959</u> Death occurred at <u>8:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>D. P. [Signature]</u>						22b. ADDRESS <u>Aurora, Missouri</u>				22c. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-27-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park Cemetery</u>				23d. LOCATION (City, town, or county) (State)- <u>Aurora, Missouri</u>							
24. FUNERAL DIRECTOR ADDRESS <u>[Signature] Aurora, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>Aug. 29, 1959</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

(Licensed Embalmer's Statement on Reverse Side)

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 *[Signature]*, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Signature]*

Licensed Embalmer No. 3812

P. O. Address *[Signature]*

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.