

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032925

FILED VS SEP 2 8 1959

Registration District No. 171 Primary Registration District No. 42 Registrar's No. 46

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wasson Washington</u>		Length of stay in 1b		c. CITY OR TOWN <u>Mayview</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>In yard of his home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR #1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Ulysses E</u> Middle <u>Johnson</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucas</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>Oct 1, 1916</u>		9. AGE (last birthday) <u>42</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>Refiner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Special Road Dept</u>			11. BIRTHPLACE (City and state or country) <u>Higginsville Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Sam Johnson</u>				13b. MOTHER'S MAIDEN NAME <u>Bettie Ann Duncan</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>no</u>			16. SOCIAL SECURITY NO. <u>497-348615</u>			17. INFORMANT <u>Johnnie Johnson</u>			Address <u>2 St. Lexington 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>Shot gun wounds of left chest</u> DUE TO (b) <u>Homicide</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Found shot to death in the yard of his home</u>								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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Gun shot. Found dead face down</u>									
20c. TIME OF INJURY Hour <u>11?</u> Month, Day, Year <u>Aug 30 1959</u> a.m. p.m. <u>in the yard of his home</u>		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.) <u>at his home</u>		20f. CITY, TOWN, OR LOCATION <u>Mayview Lafayette Mo</u>		COUNTY		STATE			
21. I attended the deceased from <u>after death</u> to _____ and last saw him alive on <u>more than a year ago</u> Death occurred at <u>probably 10-12 PM Aug 31-59</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>M Martin MD Coroner</u> (Degree or title)						22b. ADDRESS <u>Odean Mo</u>			22c. DATE SIGNED <u>9-2-59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept-7-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Muncie Cemetery Higginsville Mo.</u>				23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR <u>George H Green Marshall Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>9/25/1959</u>		26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 28 1959

**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 Gayathreen

Licensed Embalmer No. 4220

P. O. Address New York

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.