

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 21 1959

'59 0 4 3 9 2 3

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1363

ENDED

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b	c. CITY OR TOWN LONG GROVE Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA BURGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE # 1 BOX # 33 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ODIS Middle W. Last JOHNSON			4. DATE OF DEATH Month DEC. Day 15 Year 1959				
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/5/26	9. AGE (last birthday) 33	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARNIVAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY SHOW BUSINESS		11. BIRTHPLACE (City and state or country) WINSBORO, LA.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JAMES JOHNSON		13b. MOTHER'S MAIDEN NAME MARTIS BOWLIN		14. NAME OF HUSBAND OR WIFE WILMA M. JOHNSON			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W. # 2	16. SOCIAL SECURITY NO. 405-30-2747	17. INFORMANT Address Mrs. Wilma Johnson Long Grove, Iowa
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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) <i>Likely Coronary Occlusion</i> DUE TO (b) <i>Likely Rheumatic heart disease</i> DUE TO (c) UNATTENDED BY A PHYSICIAN		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>
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 Month, Day, Year a.m. p.m.	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

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at **2:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>James P. Cross, M.D.</i>		22b. ADDRESS Greene County Health Officer Spfld Mo		22c. DATE SIGNED 12-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec 17, 1959	23c. NAME OF CEMETERY OR CREMATORY Gulf Port Mississippi		(State)
24. FUNERAL DIRECTOR H.H. LOHMEYER SPRINGFIELD MO.		25. DATE RECD. BY LOCAL REG. 12-17-59	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6981 83.0977

JAN 26 1960

STATEMENT BY LICENSED EMBALMER

DEC 8

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 J. J. Mc Conn

Licensed Embalmer No. 2727

P. O. Address Springfield

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.