

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-002088**

**FILED VS FEB 3 1960 50**

STATE FILE NUMBER

Registration District No. 4241 Primary Registration District No. 34 Registrar's No. 34

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oak Grove</u>		Length of stay in 1b <u>11 yrs</u>		c. CITY OR TOWN <u>Oak Grove</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>City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>City</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh</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>4-24-1874</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>			11. BIRTHPLACE (City and state or country) <u>Darville Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13. FATHER'S NAME <u>Jacob Johnson</u>				13b. MOTHER'S MAIDEN NAME <u>Jane Dooley</u>				14. NAME OF HUSBAND OR WIFE <u>Mollie Johnson</u>					
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>Mollie Johnson</u> Address <u>Oak Grove 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>Coronary occlusion</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <input type="checkbox"/>													
DUE TO (c) <input checked="" type="checkbox"/>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>													
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 <u>1925</u> to <u>Jan. 27, 1960</u> and last saw her/him alive on <u>Jan. 27, 1960</u> Death occurred at <u>11 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>Oak Grove Mo.</u>			22c. DATE SIGNED <u>1-29-60</u>				
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-30-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Darville Mo.</u>					
24. FUNERAL DIRECTOR <u>Webb Funeral Home</u> ADDRESS <u>Oak Grove Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-1-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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 RBW

Licensed Embalmer No. 2353

P. O. Address Blue Spring

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.