

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002438

FILED VS FEB 15 1960

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 5691 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson Twp.</u>		Length of stay in 1b <u>5 yrs</u>	c. CITY OR TOWN <u>Brookfield</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>RFD #1, Brookfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE BELL JOHNSON</u>			4. DATE OF DEATH Month Day Year <u>Feb. 8, 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Meadville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>		
13a. FATHER'S NAME <u>Joseph F. Hicks</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Martin</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel D. 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 Address <u>Mrs. Ida Straub, R 1, Brookfield, 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>Uremia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>	
DUE TO (b) <u>Cerebral vascular accident</u>					<u>1 mo.</u>	
DUE TO (c) <u>Generalized arteriosclerosis & Hypertension</u>					<u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</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 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	
21. I attended the deceased from <u>2-10-53</u> , to <u>2-8-60</u> , and last saw her/him alive on <u>2-8-60</u> . Death occurred at <u>7:45 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>J.W. Bohner Sr.</u>			22b. ADDRESS <u>Brookfield Mo.</u>		22c. DATE SIGNED <u>2/11/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 10, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ogan Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brookfield, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wright Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-12-60</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Reg.</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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.