

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-018072

FILED VS MAY 11 1960 356

Registration District No. \_\_\_\_\_ Primary Registration District No. 4521 Registrar's No. 38

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Texas</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Houston</b>	Length of stay in 1b <b>8 1/2 mos.</b>	c. CITY OR TOWN <b>Houston</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Melborn</b> Last <b>Johnson</b>			4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>60</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Greenfield, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Edwin Johnson</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie Shelby</b>		14. NAME OF HUSBAND OR WIFE <b>Helen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>500-40-8067</b>		17. INFORMANT Address <b>Mrs. Helen Johnson, Houston, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>advanced pulmonary emphysema</b>		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	
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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 **6-20-57** to **4-27-60** and last saw him alive on **4-27-60**  
Death occurred at **6:30 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Paul H. Beckman M.D.</b>		22b. ADDRESS <b>Houston, Missouri</b>		22c. DATE SIGNED <b>5-4-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Scott Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Scott, Indiana</b>	

24. FUNERAL DIRECTOR ADDRESS <b>Raymond E. Duff, Houston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5/5/60</b>	26. REGISTRAR'S SIGNATURE <b>Myrtle Craig m.s.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 18 1960

**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 Frank E. Wood

Licensed Embalmer No. 402

P. O. Address Houston, T

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.