RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 16 1960

-60-031370
STATE FILE NUMBER

Registration District No. 210 Primary Registration District No. 4322 Registrar's No. 57

1. PLACE OF DEATH
a. COUNTY: Mercer County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Princeton,Mo
Length of stay in 1b: 2yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lambert Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Mercer
c. CITY OR TOWN: Princeton,Mo
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Roma Middle: Last: Johnson
4. DATE OF DEATH: Month 8 Day 8 Year 60

5. SEX: female
6. COLOR OR RACE: white
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-6-1889
9. AGE (last birthday): 71
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): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Harrison Co.,Mo
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: B. R. Wilson
13b. MOTHER'S MAIDEN NAME: Roda Woodward
14. NAME OF HUSBAND OR WIFE: Cliff Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Cliff Johnson Address: Princeton,Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclorosis — unknown
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronichial asthma and emphysema
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Aug 7, 60, to Aug 8, 60 and last saw her/him alive on aug 8, 60
Death occurred at 8:45 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Frank H Zahn MD (Degree or title)
22b. ADDRESS: Princeton, Mo
22c. DATE SIGNED: 8-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 8-10-60
23c. NAME OF CEMETERY OR CREMATORY: Glaze Cemetery
23d. LOCATION (City, town, or county) (State): Harrison Co.,Mo

24. FUNERAL DIRECTOR ADDRESS: Noel Moss Princeton,Mo
25. DATE RECD. BY LOCAL REG.: 8-8-60
26. REGISTRAR'S SIGNATURE: Noel Moss

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT 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 me, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Hal Mass

Signature of Student Embalmer

Licensed Embalmer No. 263

P. O. Address Juneta

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.