

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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**-60-034426**

FILED VS OCT 17 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1027

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield, Missouri</b>		Length of stay in 1b <b>54 Days</b>		c. CITY OR TOWN <b>Hickory</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 <b>Medical Center for Federal Prisoners</b>				d. STREET ADDRESS (If outside, give location) <b>R.R. #1 Box 108</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joe Nathan JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>10 12 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6/2/22</b>			
9. AGE (last birthday) <b>38</b>		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) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Hickory, Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Richard Johnson</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Tellieh Johnson</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1943 to 1946</b>			16. SOCIAL SECURITY NO. <b>231-01-0199</b>		17. INFORMANT <b>MCFP - Files</b>			Address <b>Springfield, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>Uremia</b>							<b>3 Months</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterioneophrosclerosis</b>							<b>1 Year</b>		
DUE TO (c) <b>Malignant hypertension</b>							<b>2 Years</b>		
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 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 <b>8/18/60</b> to <b>10/12/60</b> and last saw her/him alive on <b>10/12/60</b> Death occurred at <b>8:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Jesse D. Harris</b> (Degree or title) <b>JESSE D. HARRIS, M.D. Acting Clinical Director</b>				22b. ADDRESS <b>MCFP, Springfield, Missouri</b>			22c. DATE SIGNED <b>10/13/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>NORFOLK, VA.</b>		(State)	
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>10-14-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>			

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

*H. L. McCormick*

Licensed Embalmer No. 5727

P. O. Address *St. Louis, 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.