

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013364  
STATE FILE NUMBER

Dr. Lemmon  
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 424

AMENDED FILED MAY 8 1961

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 10 YRS.		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2102 KINGS			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES S. JOHNSTON				4. DATE OF DEATH Month Day Year APRIL 29 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6/5/92	9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY FRISCO R.R.		11. BIRTHPLACE (City and state or country) MONETT, MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JAMES JOHNSTON			13b. MOTHER'S MAIDEN NAME ANN MCGINNIS		14. NAME OF HUSBAND OR WIFE ARTIE JOHNSTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W. # 1				17. INFORMANT MRS. ARTIE JOHNSTON SPRINGFIELD, MO			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
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 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 Month, Day, Year a.m. p.m.							
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>4-27-61</u> to <u>4-29-61</u> last saw him alive on <u>4-29-61</u> Death occurred at <u>2:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>S. Lemmon M.D.</i> (Degree or title)				22b. ADDRESS Springfield, Mo.			22c. DATE SIGNED 5-1-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/2/61	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY		23d. LOCATION (City, town, or county) MONETT, MO.		(State)
24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.				25. DATE RECD. BY LOCAL REG. 5-1-61		26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>	

MAY 9 1961

MAY 26 1961

MAY 16 1961

NOV 28 1961

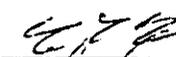
**STATEMENT BY LICENSED EMBALMER**

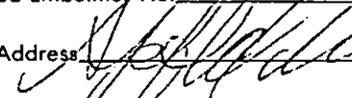
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed 

Licensed Embalmer No. 

P. O. Address 

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.

