

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018194

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 73

AMENDED

FILED JUN 5 1961

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| 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>Chariton</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u> | | Length of stay in lb | c. CITY OR TOWN <u>ROTHVILLE</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pershing M. Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u></u> |
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA MAE JOHNSON</u> | | | 4. DATE OF DEATH Month Day Year <u>5/27-1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/4/1882</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months Days <u>11 23</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | 11. BIRTHPLACE (City and state or country) <u>CORNING Iowa</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>GEORGE COOPER</u> | | 13b. MOTHER'S MAIDEN NAME <u>DIANA HELSEBY</u> | | 14. NAME OF HUSBAND OR WIFE <u>CHAS. 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 <u>Ralph Cooper CORNING, Iowa</u> | |

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| 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) <u>Acute Coronary occlusion</u> | | <u>15 min.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | |
| DUE TO (b) | | |
| DUE TO (c) | | |

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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) | | 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 type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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. <u></u> | Month, Day, Year <u></u> | | |
| 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 Patient first seen by me 15 min. after death and his last seen alive on
Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Dr. R. L. Ryals R.L. Ryals D.O.</u> | | 22b. ADDRESS <u>Erookfield, Missouri</u> | 22c. DATE SIGNED <u>5-29-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5/30/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Quincy</u> | 23d. LOCATION (City, town, or county) (State) <u>CORNING Iowa</u> |
| 24. FUNERAL DIRECTOR <u>S. L. Shepard MENDONMO</u> | | 25. DATE RECD. BY LOCAL REG. <u>5-29-61</u> | 26. REGISTRAR'S SIGNATURE <u>Harold W. White M.D.</u> |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Billie C. Gonder

Licensed Embalmer No. 4980

P. O. Address Mendon, Mo

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.