

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041597

MENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 118

AMENDED **FILED DEC 14 1961**

1. PLACE OF DEATH a. COUNTY Lawrence County, Missouri				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Carter									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in 1b 75		c. CITY OR TOWN Ellsinore		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS RR #1 (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) James Clifford Johnson				4. DATE OF DEATH Month 12 Day 3 Year 61									
5. SEX M.		6. COLOR OR RACE W.		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-1-00		9. AGE (last birthday) 61		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) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Crane, Missouri			12. CITIZEN OF WHAT COUNTRY U.S.A				
13a. FATHER'S NAME J.R. Johnson				13b. MOTHER'S MAIDEN NAME Annabelle Teague				14. NAME OF HUSBAND OR WIFE Edna Pearl Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						17. INFORMANT Hospital Records, Mo. S. San. Address: Mt. Vernon, Mo. Deceased - J.C. Johnson, Mo. S. San.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis, Pulmonary, F.A.										INTERVAL BETWEEN ONSET AND DEATH			
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). Myocardial Infarction-old										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 9-19-61 to 12-3-61 and last saw him alive on 12-3-61 Death occurred at 6:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Samuel R. Wilson M.D. (Degree or title)						22b. ADDRESS Mo. State Sanatorium, Mt. Vernon				22c. DATE SIGNED 12-3-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-3-61		23c. NAME OF CEMETERY OR CREMATORY Van Buren Cemetery			23d. LOCATION (City, town, county) (State) Van Buren Mo.						
24. FUNERAL DIRECTOR Pewitt Funeral Home ADDRESS Van Buren Mo.				25. DATE RECD. BY LOCAL REG. 12-7-61		26. REGISTRAR'S SIGNATURE Kay Wayne							

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1941 1017 37114

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 H. H. Torrey

Licensed Embalmer No. 2206

P. O. Address Hickory

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.