

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-005301

STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 9

AMENDED

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY <b>WEBSTER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>WEBSTER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MARSHFIELD</b>		c. CITY OR TOWN <b>MARSHFIELD MO</b>	
Length of stay in lb <b>5 YRS</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Dyck &amp; Kemp.</b>		d. STREET ADDRESS (If outside, give location) <b>1 mi South</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>F.</b> Last <b>JOHNSON</b>			4. DATE OF DEATH Month <b>JAN</b> Day <b>22</b> Year <b>1962</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-1895</b>	9. AGE (last birthday) <b>76</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>RET FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOEL JOHNSON</b>		13b. MOTHER'S MAIDEN NAME <b>LOUISA HAKE</b>		14. NAME OF HUSBAND OR WIFE <b>CAARA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>CAARA JOHNSON MARSHFIELD</b> Address			

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>		
DUE TO (b) <b>ARTERIOLEAR NEPHROSCLEROSIS</b>		
DUE TO (c) <b>ARTERIOSCLEROSIS.</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 <b>Marshallfield, Mo.</b>	COUNTY <b>WEBSTER</b>	STATE <b>MO</b>
21. I attended the deceased from <b>1/6/62</b> to <b>1/22/62</b> and last saw <sup>from</sup> him alive on <b>1/20/62</b> Death occurred at <b>1245 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Ch. Blum, D.O.</b>		(Degree or title)		22b. ADDRESS <b>Marshallfield, Mo.</b>		22c. DATE SIGNED <b>1/25/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-24-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROPER</b>		23d. LOCATION (City, town, or county) (State) <b>WACHEDE CO MO</b>	
24. FUNERAL DIRECTOR <b>BARBER-EDWARDS MARSHFIELD</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1/29-62</b>		26. REGISTRAR'S SIGNATURE <b>Stramer's</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

FEB 15 1962

**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 George Stapp

Licensed Embalmer No. 3161

P. O. Address M. L. Bencini

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.