

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037209

STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 219

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0887

2 0887

3 2

4 2

5 0

6

7 0

8 2

9 9/160

10 16

11 127

12 90-2

13 30

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		c. CITY OR TOWN Moberly	
Length of stay in 1b 6-Years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 917-Fisk Ave.		d. STREET ADDRESS (If outside, give location) 917 - Fisk Ave.	
3. NAME OF DECEASED (Type or print) Charles Vernon Johnson		4. DATE OF DEATH Month Oct. Day 2nd , Year 1963	
5. SEX Male	6. COLOR OR RACE Black	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1930
9. AGE (last birthday) 33		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Keytesville, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Azor Johnson	
13b. MOTHER'S MAIDEN NAME Sarah Johnson		14. NAME OF HUSBAND OR WIFE Sarah Washington, Moberly, Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War - Two		16. SOCIAL SECURITY NO. NOT KNOWN	
17. INFORMANT Sarah Washington, Moberly, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medulary failure		INTERVAL BETWEEN ONSET AND DEATH 1 Inst	
DUE TO (b) Sufication		Nearly Inst.	
DUE TO (c) Smoke from burning house		?	
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 checked="" 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.) House was on fire from unknown origin. Found	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. dead in room.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		20f. CITY, TOWN, OR LOCATION COUNTY STATE Moberly Randolph Mo.	
21. I attended the deceased from _____, to _____ and last saw her him alive on _____. Death occurred at 2:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Ben S. O'Leary</i>		22b. ADDRESS 203 1/2 N. Clark, Moberly, Mo.	
22c. TITLE Coroner		22d. DATE 10-2-1963	
23a. NAME OF CEMETERY OR CREMATORY City Cemetery		23b. LOCATION (City, town, or county) (State) Keytesville, Mo.	
24. FUNERAL DIRECTOR H. D. Garnett		25. DATE RECD. BY LOCAL REG. 10-2-1963	
ADDRESS Keytesville, Mo.		26. REGISTRAR'S SIGNATURE <i>W. Paul White</i>	

USE BLACK INK OR TYPEWRITER RIBBON

OCT 15 1963

OCT 30 1963

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. D. Gault*

Licensed Embalmer No. 3046

P. O. Address *Key Transit Co.*

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.

Permit Renewed 10-2-63