

FILED FEB 14 1941

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

2695

Do not use this space.

1. PLACE OF DEATH

 (a) County Henry Registration District No. 349
 (b) Township Eden Primary Registration District No. 4207
 (c) City Calhoun (d) Street No. 117 St. 0
 (e) Length of residence in city or town where death occurred 56 yrs. mos. ds. (f) How long in U. S., if of foreign birth, yrs. mos. ds.
2. PRINT FULL NAME William L. Johnson
 (a) Residence, No. 0 St. 0 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minerva Josephine Johnson
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 30, 1885
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 8 27

 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mechanicsburg, Pa.
 FATHER
 13. NAME John Johnson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

 MOTHER
 15. MAIDEN NAME Jemima Arnold
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.
17. INFORMANT (ADDRESS) J. W. Edwards
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Calhoun DATE Jan 28, 1941
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Edwards20. FILED Jan 21, 1941 Miss Edith J. Simpson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 26, 1941
 22. I HEREBY CERTIFY, that I attended deceased from Sept 10, 1940 to Jan 26, 1941
 I last saw him alive on Jan 26, 1941. Death is said to have occurred on the date stated above, at 12:30 am.
 The principal cause of death and related causes of importance were as follows:

Bronchial pneumonia Date of onset 1/20/41
Other contributory causes of importance: 107
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? no

 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

 Manner of injury.....
 Nature of injury.....

 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify.....
 (Signed) J. W. Edwards M. D.
 (Address) Calhoun

RECEIVED

District Health Officer No. 7,

District File Number 2-41-102

Date Filed 2-3-41

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, J. H. Housey

....., or by

Registered Apprentice No., working under my personal supervision.

Signed J. H. Housey

Licensed Embalmer No. 31702

P. O. Address Calhoun Ave

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2695-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 349

Primary Registration District No. 4207

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Calhoun
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Wm L Johnson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 - 8 27 min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Jan 25 1941 (Date received local registrar) (b) Mrs. Edith Simpson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Calhoun
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH Month Jan day 21 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury _____

23. Signature J. A. Ballard (M. D. or other)

Address Calhoun Mo Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

