No. 2
9-4-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10331

FILED APR 14 1943

Registration District No. 1337 Primary Registration District No. 3023 Registrar's No. 68

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Clinton Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 64.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry 42
(c) City or town Calhoun Mo 0
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joseph H Johnson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Elizabeth Johnson
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased March (Month) 13 (Day) 1874. (Year)

8. AGE: Years 69 Months 0 Days 11 If less than one day hr. min.

9. Birthplace Paris Mo (City, town, or county) (State or foreign country) 0
10. Usual occupation Farmer
11. Industry or business

MOTHER FATHER
12. Name Samuel H Johnson
13. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
14. Maiden name Lillian Collins
15. Birthplace Va. 1 (City, town or county) (State or foreign country)

16. (a) Informant Elizabeth Johnson
(b) Address Calhoun Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 25 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Calhoun Mo
18. (a) Signature of funeral director J A Dawsey
(b) Address Calhoun Mo
19. (a) March 25 1943 (Date received local registrar) (b) Georgia Kitchen (Registrar's signature)

1067 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1943 hour 11 minute 40 P.M.

21. I hereby certify that I attended the deceased from Feb 28, 1943 to March 24 1943
that I last saw him alive on March 24 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia (Duration) 2 days.
Due to
Due to
Other condition Chronic Tuyocarditis 5 Years
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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

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

23. Signature Wm R S Hallenquest M.D. or other
Address Clinton Mo Date signed 3/25/43

RECEIVED
District Health Officer No. 7
District File Number 3-43-112
Date Filed 7-13-43

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 Myself, ..., Registered Apprentice No. ..... working under my personal supervision.

Signed J A Hainey

Licensed Embalmer No. 3502

P. O. Address Calhoun Ga

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
21-41
29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10331

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 68

1. PLACE OF DEATH:

(a) County Henry (b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Clinton Nursery Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 64

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph H. Johnson
3. (b) If veteran, name war (c) Social Security No.

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

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

7. Birth date of deceased March (Month) 13 (Day) 1874 (Year)

8. AGE: Years 69 | Months 0 | Days 17 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER / FATHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 24 year 1943 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 Hypostatic Pneumonia — Duration 2 days
Due to Lobar pneumonia.
Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

5900 PHYSICIAN

Underline the cause to which death should be charged statistically.

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

23. Signature Dr. R. S. Bollinger (Attending physician or coroner)
Address Clinton. Date signed 3/1/43

SUPPLEMENTARY