S. No. 2
M—5-43
5-17-39
X34671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25120

Registration District No. 296 Primary Registration District No. 6019 Registrar's No. 25

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Near Floyd Mo. Orrick Tp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 48
(c) City or town Kansas City, Mo. 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1614 Olive 8
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME William Taylor (Alias) Cecil W. Johnson
3. (b) If veteran, name war none
3. (c) Social Security No.
4. Sex Male 2
5. Color or race Col
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 12 (Day) 1912 (Year)

8. AGE:

Years	Months	Days	If less than one day
35	5	13	hr. min.

9. Birthplace Monroe City (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Laborer Railroad
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Gertie Cord
15. Birthplace Paris, Mo. (City, town, or county) (State or foreign country) 0
16. (a) Informant Lucile Taylor
(b) Address 1614 Olive St. Kansas City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cem K. C. Mo.
18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia K. C. Mo
19. (a) 6/26/47 (Date received local registrar) (b) Helen J. Larker (Registrar's signature) 097

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25 year 1947 hour 4 minute 30 P M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Hit by a train, accident
Due to
Due to 8
Other conditions 8
(Include pregnancy within 3 months of death) 19
Major findings:
Of operations 1 9 3
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: 89
(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? 3
(Specify type of place)
While at work? (e) Means of injury
23. Signature John F Baber Coroner (M. D. or other)
Address Richmond Mo Date signed 6-26-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number _____

Date Filed 8-8-47

SEP 1 1948

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 Self

_____, Registered Apprentice No. _____,

working under my personal supervision.

Signed Victor E Jennings

Licensed Embalmer No. 2896

P. O. Address 2896 Liberty Mo

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, fact should be so stated above.

No. 2B
M—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec 9

Registration District No. 296 Primary Registration District No. 6019 Registrar's No. 25

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

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural
(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 years, months or days)

In this community

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 W Gaylor C.W. Johnson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Jan 12 1912
(Month) (Day) (Year)

8. AGE: Years 35 Months V Days 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

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

MOTHER
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 June Day 25 year 1947 hour about noon minute M.

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

	Duration
Immediate cause of death He was walking on railroad right of way when struck by a train	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 16 9
Of autopsy NO

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) Accident

(b) Date of occurrence June 25 1947

(c) Where did injury occur Near Avis Ray Co (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Railroad Track (Specify type of place)

While at work? No (e) Means of injury

23. Signature John F Baber Coroner (M. D. or other)

Address Richmond Mo Date signed 8/15/47

SUPPLEMENTARY

S-25120