

AUG 1 1940

State File No. _____

Registration District No. 914 Primary Registration District No. 6235 Registrar's No. _____

1. PLACE OF DEATH: Ray

(a) County: _____

(b) City or town: Rural Cape Girardeau Twp.
(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) 2

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 2 mos. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Ray

(c) City or town: Ray Rural
(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.

3. (a) PRINT FULL NAME: Clyde Wm Johnson

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1940 hour 7 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 10 1940 to July 23 1940 and that death occurred on the date and hour stated above.

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

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

7. Birth date of deceased: Carol W. mo may 27-1880 (Day) (Year)

Immediate cause of death: Fever intermittent

Duration: not known

8. AGE: Years 60 Months 1 Days 24 If less than one day hr. _____ min. _____

Due to: _____

Due to: 28

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

10. Usual occupation: Out of Employment

11. Industry or business: _____

12. Name: Isaac Johnson

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

14. Maiden name: Lemah Tobey

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

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations: _____ Of autopsy: _____

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

16. (a) Informant: Sadie Johnson (b) Address: Ray Mo

17. (a) Burial (b) Date thereof: 7-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Erion Cemetery

18. (a) Signature of funeral director: B. T. Mead (b) Address: Ray Mo

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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) (e) Means of injury: _____

23. Signature: Henry J. Patterson (M. D. or other) _____

Address: Ray Mo Date signed: 7/24/40

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

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

Signed.....

Bernard L. Mead

Licensed Embalmer No.....

2801

P. O. Address.....

Braymer, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 26107

Registration District No. 914

Primary Registration District No. 6235

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Ray
(b) City or town London Grove, T.O.
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Elizabeth Wm 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
60 1 26 _____ 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) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Isaiah Mausur
(Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH month July day 23
year 1940 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 _____

Duration

Due to _____

Due to _____

Other conditions (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?

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

I have no record of this death certificate - none received by me

