S. No.
M—9-4-41
v. 5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28001

FILED SEP 14 1942

Registration District No. 297 — Primary Registration District No. 6020 — Registrar's No. 19

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

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Crooked river R. R No 2
(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
In this community 73 yeas (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State — (b) County 0
(c) City or town 0
(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 0

3. (a) PRINT FULL NAME Louis Ely Johnson
3. (b) If veteran, name war
3. (c) Social Security No. yes

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sula M Seibold
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased April - 13 - 1869 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	4	13	hr. min.

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

FATHER
12. Name John W Johnson
13. Birthplace St Louis Co Ill (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lydia Ann Dye
15. Birthplace Ray Co Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Clifton Johnston
(b) Address Orrick Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-42 (Month) (Day) (Year)
(c) Place: burial or cremation Lovelock Cem
18. (a) Signature of funeral director Jno W. Kneipschild
(b) Address Hardin Mo
19. (a) August 29 1942 (Date received local registrar) (b) Mrs. Chas W Sheppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1942 hour 2 minute 30 P M.

21. I hereby certify that I attended the deceased from Aug 23, 1942, to Aug 27, 1942 that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	4 days
Due to	
Due to	
Other conditions Hypertension (Include pregnancy within 3 months of death)	4 years

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 Dr. E. G. Reven (M.D. or other)
Address Richmond Mo — Date signed Aug 29, 42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 8,
OCT 29 1942
District File Number
Date Filed 9-11-42

MAY 31 1945

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

Signed John W. Knipschild
Licensed Embalmer No. 2789
P. O. Address Hardin 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.

V. S. No. 2B
10M—8-21-41
I X29288

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. 28001

Registration District No. 297 Primary Registration District No. 6020 Registrar's No. 19

1. PLACE OF DEATH:

(a) County.....

(b) City or town.....
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray

(c) City or town R. R. No. 2
(If outside city or town limits, write "RURAL")

(d) Street No. R. R. No. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Louis Ely Johnson

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex.....

5. Color or race.....

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 April 13 1879
(Month) (Day) (Year)

8. AGE: Years 63 Months 4 Days If less than one day hr. min.

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

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) Aug. 29-1942 (b) Mrs. Chas. N. Heppard
(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27
year 1942 hour..... 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.....	
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?
(Specify type of place)
While at work?..... (e) Means of injury.....

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

Address..... Date signed.....