S. No. 2
1—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28332

State File No.

Registration District No. 21

Primary Registration District No. 3793

Registrar's No.

1. PLACE OF DEATH:
(a) County Montrose
(b) City or town Jamestown
(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 Almost 83 y (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Alexandrine Knox 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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 22 (Month) 1863 (Day) (Year)

8. AGE: Years 81 Months 8 Days 24 If less than one day hr. min.

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

FATHER
12. Name Isaiah Vivian Johnson
13. Birthplace Jamestown (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name Rachel Hall
15. Birthplace Jamestown (City, town, or county) (State or foreign country) 0

16. (a) Informant L. R. Johnson
(b) Address Jamestown Mo
17. (a) Union Cemetery (Burial, cremation, or removal) (b) Date thereof Aug 26 (Month) (Day) (Year)
(c) Place: burial or cremation Mysore Cemetery
18. (a) Signature of funeral director Dean C. Fullbright
(b) Address Jamestown
19. (a) Aug 23 1944 (Date received local registrar) Grace Kuntz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
year 1944 hour 16 minute 5 P. M.
21. I hereby certify that I attended the deceased from Jan 1, 1944 to Aug 24, 1944 that I last saw him alive on Aug 15, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of stomach	3
Due to	2
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 A L Meredith (M. D. or other)
Address Princeton Mo Date signed 8-26-44

511

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9

District File Number .....

Date Filed 9-12-44

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 Hugh E. Hellman

Licensed Embalmer No. 3537

P. O. Address California Masonic

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.

S. No. 2B
)M—5-43
I X38930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept.

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

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

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Jonesburg
(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 _____ (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 Noadiah R. 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 S
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec (Month) 22 (Day) _____ (Year)

8. AGE: Years 81 Months 8 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) 8-27-194[illegible] (Date received local registrar) (b) _____ (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day _____ year 194[illegible] 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 _____

28332