N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D OCT 20 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 32241

1. PLACE OF DEATH Greene 2
(a) County ..... Registration District No. 318
(b) Township ..... Primary Registration District No. 2001 Registered No. 731
(c) City Springfield (d) Street No. 1523 Washington St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME WILLHILMINA JOHNSON 525
(a) Residence, No. 1523 Washington St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 1 - 1846
7. AGE ✓ YEARS 91 MONTHS 10 DAYS 25 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as saw mill, bank, etc. In home
10. Date deceased last worked at this occupation (month and year) ✓
11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden 9

FATHER
13. NAME Unk Frosburg 7
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden 6

MOTHER
15. MAIDEN NAME Unknown 1
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) N. H. Kruse Springfield Mo.
18. BURIAL, CREMATION, OR REMOVAL Swedeborg Mo. DATE Sep. 28 38
PLACE
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Klingner Springfield Mo.
20. FILED Sept 26 1938 Chas A. George MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 26, 1938
22. I HEREBY CERTIFY, That I attended deceased from ....., 1936, to Sept 26, 1938
I last saw h CL alive on June 1, 1938. Death is said to have occurred on the date stated above, at 4 A.m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Found dead in bed. Date of onset 9/26/36
Other contributory causes of importance: Arterio-Sclerosis 82a
Name of operation None Date of ..... No
What test confirmed diagnosis? None Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) C. Max Fitzt, M. D.
(Address) Springfield Mo.

Licensed Embalmer's Statement on Reverse Side

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, Roy A. Cav
#1763 Warren D. Noblett #4005, ~~or~~ by Wm. Max Rhodes

Registered Apprentice No. 117, working under my personal supervision.

Signed J B Klingner

Licensed Embalmer No. 3358

P. O. Address Springfield, M

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

If this body is not embalmed, above space should be left blank.