

DEC 19 1938

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

39609  
Do not use this space.

1. PLACE OF DEATH

(a) County Jay Registration District No. 460  
 (b) Township Paris Primary Registration District No. 4274  
 (c) City Jay (d) Street No. \_\_\_\_\_ 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

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
535 Mrs. Flora Elizabeth Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>E. J. Johnson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 15, 1863</u>		
7. AGE YEARS <u>74</u>	MONTHS <u>11</u>	DAYS If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired Journalist</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	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) <u>Lexington Mo.</u>		
FATHER	13. NAME <u>Albert E. Blewett</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bowling Green Kentucky</u>	
MOTHER	15. MAIDEN NAME <u>Mary Rosanna Hagood</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
17. INFORMANT (ADDRESS) <u>Stanley B. Johnson</u> <u>Jay Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>City Cemetery</u> DATE <u>Nov 17 1938</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. A. James</u> <u>Jay Mo</u>		
20. FILED <u>Dec 1 1938</u> <u>Jessie Wable</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 14 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov 12 1938 to Nov 14 1938  
 I last saw her alive on Nov 14 1938. Death is said to have occurred on the date stated above, at 6:30 pm.  
 The principal cause of death and related causes of importance were as follows:  
Paralysis of left side Date of onset \_\_\_\_\_  
Bright's + Myocarditis  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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) W. A. MacKreim M. D.  
Jay Mo (Address)

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.

935

RECEIVED  
District Health Officer No. 8,  
District File Number 12/9/38  
Date Filed

ASA BARNES, M. D.  
Assistant Special Agent,  
Bureau of the Census,  
HIGGINSVILLE, - MISSOURI.

**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 E. S. James

Licensed Embalmer No. 2058

P. O. Address Concordia 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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39609  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Lafayette Registration District No. 460  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4274 Registered No. \_\_\_\_\_  
 (c) City Higginsville (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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 Mrs Flora Elizabeth Johnson  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>74</u>	<u>11</u>		

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_ 19\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_ to \_\_\_\_\_ 19\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

paralysis of left side  
7. m. o.

Date of onset

Other contributors causes of importance:

Bright + meg. cardiac  
chronic. 121

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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?

If so, specify \_\_\_\_\_

(Signed) W. V. Braeclum, M. D.

(Address) Higginsville

Local Registrar

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTAL

