

MAY 12 1939

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

14412

Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township _____ Primary Registration District No. 3008 Registered No. 107
 (c) City Fulton (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 21, 1856

7. AGE YEARS 83 MONTHS 2 DAYS 16 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Publisher
 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) 1938
 11. Total time (years) spent in this occupation 1938

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Joel P. Johnston

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

15. MAIDEN NAME Virjane Reed

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

17. INFORMANT (ADDRESS) J. P. Johnston, Fulton, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillcrest Cem. DATE April 8, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leah Wallace, Fulton, Missouri

20. FILED April 8, 1939 P. N. Crewe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/7/39, 19

I HEREBY CERTIFY That I attended deceased from 3/15/39, 19, to 4/7/39, 19, that saw him alive on 4/7/39, 19. Death is said

to have occurred on the date stated above, at 5:10 P.M.
 The principal cause of death and related causes of importance were as follows:

Embolysm Coronary, following arteriosclerosis, with paralysis of speech center. hypertention

Date of onset

Other contributory causes of importance: Gastrointestinal disturbance with diarrhea, and nausea.

Name of operation _____ Date of _____
 What test confirmed diagnosis? P.E. 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) [Signature], M. D.
 (Address) Fulton Missouri

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.

948

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 Leo G. Wallace

Licensed Embalmer No. 3373

P. O. Address Fulton 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.

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1. PLACE OF DEATH
 (a) County Callaway Registration District No. 104
 (b) Township _____ Primary Registration District No. 3008 Registered No. 107
 (c) City Fulton (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 James William Johnston
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Decedent
 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.
83 2 16
 OCCUPATION 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) _____
 FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 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____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/7 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw him _____ 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:
Empyema Coronary following arteriosclerosis with Paralysis of Speech Center, Hypertension, Myocardial Infarction (6-1-39) with retrocardiac
 Other contributory causes of importance:
Disturbance intestinal disturbance with diarrhea and nausea
 Date of onset 9/13
 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) G. H. McCall _____, M. D.
 (Address) Fulton Mo
G. H. McCall

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.

SUPPLEMENTARY

