

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

26543
 Do not use this space.

REGD AUG 11 1939

1. PLACE OF DEATH *1*

(a) County *Pike* Registration District No. *689*

(b) Township *Butte* Primary Registration District No. *3053* Registered No. _____

(c) City *Louisiana* (d) Street No. *Pike Co. Hospital* 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 *25* *Gerardine Lois Johnson*

(a) Residence, No. *908 Iowa St. Louisiana Mo.* St. (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) *Single*

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *✓*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 22 - 1939*

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>3</i>	<i>17</i>	

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) *Mineral Wells, Texas*
 (STATE OR COUNTRY)

FATHER

13. NAME *Erving Johnson*

14. BIRTHPLACE (CITY OR TOWN) *Chicago, Ill.*
 (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME *Garnet Jewell*

16. BIRTHPLACE (CITY OR TOWN) *Outbrain Co., Mo.*
 (STATE OR COUNTRY)

17. INFORMANT *Mother - Hospital records*
 (ADDRESS) *Louisiana Mo.*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Review Cem.* DATE *July 10 1939*

19. FUNERAL DIRECTOR (NAME) *R. H. Hall*
 (ADDRESS) *Louisiana Mo.*

20. FILED *July 9 1939* *R. H. Hall* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *JULY 9th 1939*

22. I HEREBY CERTIFY, That I attended deceased from *7-3-39* to *7-9-39*, 19____

I last saw her alive on *7/9/39*, 19____. Death is said to have occurred on the date stated above, at *10:05 AM*

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

Terminal Pneumonia 7/7/39
acute Gastro-Enteritis 7/2/39

Date of onset

Other contributory causes of importance: *119B*

Name of operation *none* Date of _____

What test confirmed diagnosis? *Clinical* 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) *R. H. Audrae*, M. D.
Louisiana
 (Address) *620*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 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.

I X14028

RECEIVED

District Health Officer No. 10

District File Number 8-39-1342

Date Filed AUG 4 1939

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,

George O. Wagner

or by

Registered Apprentice No., working under my personal supervision.

Signed

George O. Wagner

Licensed Embalmer No.

3743

P. O. Address

Louisiana, 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.