

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.

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

31711
Do not use this space.

OCT 19 1939

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
(b) Townshp _____ Primary Registration District No. 3A01 Registered No. 2031
(c) City Kirksville (d) Street No. A. S. D. 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 10 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

525 Sarah Johnson
(a) Residence, No. 204 West Hillmore 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 Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-25-1892

7. AGE YEARS 47 MONTHS 2 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. book
9. Industry or business in which work was done, as saw mill, bank, etc. Boarding House
10. Date deceased last worked at this occupation (month and year) 8-1-1939 11. Total time (years) spent in this occupation 10 yrs.

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

FATHER 13. NAME Henry Anderson 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morland Kentucky 1 0

MOTHER 15. MAIDEN NAME Lucy Mayberry
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Jane Coby Kirksville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Lexington Mo DATE 9-28 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dee Riley Kirksville Mo

20. FILED Sept 27 1939 Spencer L. Freeman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 26 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 18 1939, to Sept 26 1939
I last saw her alive on Sept 26 1939. Death is said to have occurred on the date stated above, at 3:5 A.M.

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

Uremia (Chronic Glomerulo-nephritis)
Very large uterine fibroid
Other contributory causes of importance: 131

Name of operation Heptectomy Date of 9/19/39
What test confirmed diagnosis? Lab 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) Earl Randolph J. M.D. 0
(Address) Kirksville, Mo. 3

RECEIVED

District Health Officer No. 10

District File Number 10-29-1781

Date Filed OCT 10 1959

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.....

Licensed Embalmer No.....

P. O. Address.....

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.