

1939 OCT 23 1939

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

33065
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 55

(b) Township Auders Primary Registration District No. 6262 Registered No. 1390

(c) City _____ (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. 0 How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jessie May Johnson

(a) Residence, No. _____ 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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

7. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 30 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 3 6

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

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) New Madrid

FATHER

13. NAME Ida Mae Johnson

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

MOTHER

15. MAIDEN NAME Ida Cason

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

17. INFORMANT (ADDRESS) Ida Mae Johnson

18. BURIAL, CREMATION, OR REMOVAL PLACE Washed DATE Oct 7 1939

19. FUNERAL DIRECTOR (ADDRESS) Washburn Rural

20. FILED Oct 9 1939 Washburn Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Sept 30 1939 to Oct 6 1939

I last saw her alive on Sept 30 1939 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:
Cholera, Typhoid Date of onset _____

Other contributory causes of importance: 119

Name of operation _____ Date of _____

What test confirmed diagnosis? Cholera Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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? _____ so, specify _____
(Signed) R. G. Ellis, M. D.
(Address) Washburn

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.

541

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 2,

District File Number 1039-269

Date Filed 10-12

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)