

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

36473
Do not use this space.

1. PLACE OF DEATH
(a) County Missouri Registration District No. 1056
(b) Township Colony Primary Registration District No. 5597
(c) City _____ (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 535 Virginia Frances Johnson
(a) Residence, No. _____ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>whit</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Joseph A. Johnson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 31 1849</u>		
7. AGE	YEARS <u>90</u>	MONTHS <u>2</u>
	DAY <u>29</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>homewife</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>Harrison Co West Virginia</u>		
FATHER	13. NAME <u>John Bigler Wright</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Harrison Co West Virginia</u>	
MOTHER	15. MAIDEN NAME <u>Emily Atchison</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Harrison Co West Virginia</u>	
17. INFORMANT (ADDRESS) <u>Mrs Ella Spanghewey Rutledge Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Harmony Grove</u> DATE <u>Oct 31 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Osley Hudutakyle Rutledge Mo</u>		
20. FILED <u>Nov 1 1939</u> <u>Mrs C.M. Whick</u> <u>30</u> (Address) <u>Rutledge Mo</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 29 1939

22. I HEREBY CERTIFY That I attended deceased from not present at time of death 1939
I last saw h. c. e. alive on Oct 27, 1939. Death is said to have occurred on the date stated above, at 10 A. m.
The principal cause of death and related causes of importance were as follows:
Bronchopneumonia
Date of onset Oct 24-29

Other contributory causes of importance:
IPW

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? no
If so, specify _____
(Signed) Dr. E. S. Dennis M. D.
(Address) Rutledge Mo

RECEIVED

District Health Officer No. 10

District File Number 11-39-1905

Date Filed NOV 8 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, or by

A. C. Smith

Licensed Embalmer

Registered Apprentice No.

31689

working under my personal supervision.

Signed

Bailey Undertaking Co.

Licensed Embalmer No.

31415

P. O. Address

Puttidge

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.