

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.

Registration District No. \_\_\_\_\_ Primary Registration District No. 6-1-43

Registrar's No. 54

1. PLACE OF DEATH: Saline Farm Clay Twp.  
 (a) County \_\_\_\_\_ (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: one  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution all his life  
 In this community all his life  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Saline  
 (c) City or town Slater Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Pike Johnson 525  
 3. (b) If veteran, no name war \_\_\_\_\_  
 3. (c) Social Security No. no

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov. day 27  
 year 1939 hour 10.30 A M minute \_\_\_\_\_ M.

4. Sex male 5. Color or race white  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 21 years  
 7. Birth date of deceased November 21 1863  
 (Month) 76 (Day) 0 (Year) 6

21. I hereby certify that I attended the deceased from Nov - 20 - 1939 to Nov - 27 - 1939  
 that I last saw him alive on Nov - 27 - 1939  
 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 0 Days 6  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Myocarditis  
 Duration \_\_\_\_\_

9. Birthplace Saline Co. Mo.  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name Henry Johnson  
 18. Birthplace Ohio  
 14. Maiden name Rhoda Ann Cott  
 15. Birthplace Ind.  
 (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Joe M. Johnson  
 (b) Address Slater, Mo.  
 17. (a) burial (b) Date thereof 11-29-1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Slater, Mo.  
 18. (a) Signature of funeral director Hill Brothers  
 (b) Address Slater, Mo.  
 19. (a) 11 28 (b) W. M. Tuttle  
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicida (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature M. C. Huggins (M. D. or other) \_\_\_\_\_  
 Address Slater, Mo. Date signed 11/25/39

RECEIVED  
District Health Officer No. 8,  
District File Number  
12839  
ate Filed

**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  
Edgar Moore, Registered Apprentice No. 230  
working under my personal supervision.

Signed A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, 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.**