

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **44858**

Registrar's No. _____

Registration District No. _____

Primary Registration District No. **611**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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 impor

1. PLACE OF DEATH:
(a) County Stoddard Mo.
(b) City or town Gray Ridge, Mo.
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 23 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary M. Johnson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec, 29 - 1858
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Edmonson Co, Ky
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

MOTHER FATHER
12. Name Samuel Miller
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Lagman
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
(b) Address Gray Ridge, Mo.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Idalia, Mo.

18. (a) Signature of funeral director Allen Ellis

(b) Address Stoddard, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10 year 1939 hour 1:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from Mar 11 1939 to Mar 11 1939
that I last saw her alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension Duration 1938
Due to Chronic myocarditis 1908
Senile atrophy

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (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 Dr. L. H. Samuel (M. D. or other) _____
Address Stoddard, Missouri Date signed 10/11/39

RECEIVED

District Health Officer No. 2,

District File Number 140-203

Date Filed 1-9

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, Dec 10

....., Registered Apprentice No.....
working under my personal supervision.

Signed Arden Ellis

Licensed Embalmer No. 3869

P. O. Address Sikeston, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

44838
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard Registration District No. 839
(b) Township Richland Primary Registration District No. 6101
(c) City (d) Street No. St.
(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 Mary Johnson
(a) Residence, No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 11 17

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) (STATE OR COUNTRY)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 33, 140 J.P. Brannen Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 10 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw h. alive on ... 19... 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:

Date of onset

Other contributory causes of importance:
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? If so, specify (Signed) L. B. ... M. D. (Address) Stamfield mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

