FEB 15 1940

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

2096
Do not use this space.

1. PLACE OF DEATH
(a) County Clay — Registration District No. 203
(b) Township Platte — Primary Registration District No. 4122 — Registered No. 1
(c) City Smithville — (d) Street No. Smithville Community 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Frank Johnson 525
(a) Residence, No. Navona Mo 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 White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE Years About 67 Months Days — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
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. Housewife
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) Unk 9

FATHER
13. NAME Unk 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk 9

MOTHER
15. MAIDEN NAME Unk
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Miss Ann Naud Smithville, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty DATE Jan 11, 1940
19. FUNERAL DIRECTOR (ADDRESS) [illegible] Liberty Mo
20. FILED 1-9- 1940 E. C. Hill Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9, 1940
22. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1939, to 1-9, 1940
I last saw her alive on 1-9, 1940 Death is said to have occurred on the date stated above, at 4:02 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma head of Pancreas	9-1-39?
Obstructive Jaundice	1-1-40
46	
Other contributory causes of importance:	
Toxic Exhaustive Psychosis	1-3-40

Name of operation Cholecystostomy Date of 1-2-40
What test confirmed diagnosis? Clin & Opr. 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) Leonard Dixon, M. D.
194 (Address) Smithville, Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X12004

RECEIVED
District Health Officer No. 8
District File Number 4/3/40
Date Filed

Burial Permit

STATEMENT BY LICENSED EMBALMER

I, N H Nice, Licensed Embalmer No. 879

hereby certify that the body recorded on the reverse side of this certificate was embalmed by N H Nice

L. E. Liberty Mo.

No. 879 or by ....., Registered Apprentice No. .....

working under my personal supervision.

Signed N H Nice

Licensed Embalmer No. 879

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.)

o. 2B
21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2096

Registration District No. 203 Primary Registration District No. 4122 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Gasconade Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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) PERSONAL AND FULL NAME Mrs Loda 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 M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years aft 67. Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1-9-1940 (Date received local registrar) (b) E. C. Hill (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 9 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. Leonard Dixon (M. D. or other)
Address Gasconade Mo. Date signed