

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

3074
 Do not use this space.

FEB 15 1940

1. PLACE OF DEATH
 (a) County Marion 2 Registration District No. 548
 (b) Township Tabernash 0 Primary Registration District No. 5743 Registered No. 3
 (c) City Paylor (d) Street No. _____
 (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 John Cyrus Johnston 523
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Fanning Johnston
 7. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 21/1855
 8. AGE YEARS 84 MONTHS 4 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.
 9. TRADE, PROFESSION, OR PARTICULAR KIND OF WORK DONE, AS SAWYER, BOOKKEEPER, ETC. Farmer
 10. INDUSTRY OR BUSINESS IN WHICH WORK WAS DONE, AS SAW MILL, BANK, ETC. _____
 11. DATE DECEASED LAST WORKED AT THIS OCCUPATION (MONTH AND YEAR) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 6 1940
 22. I HEREBY CERTIFY That I attended deceased from Jan 4 1940 to Jan 4 1940
 I first saw him alive on Jan 4 1940. Death is said to have occurred on the date stated above, at 6:40 A.M.
 The principal cause of death and related causes of importance were as follows:
Infection - Bronchial Date of onset 3 days
Pneumonia - Bronchial 3 days
 Other contributory causes of importance Myocarditis Chronic
General debility
 Name of operating physician W. T. Russell 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 W. T. Russell, M. D.
W. T. Russell
W. T. Russell
 (Address) Calmyra, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paylor Mo.
 13. NAME Calvin Johnston
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paylor Mo.
 15. MAIDEN NAME Malenda Beckett
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo.
 17. INFORMANT Willie B. Jones
 (ADDRESS) Maywood, Missouri
 18. BURIAL, CREMATION, OR REMOVAL PLACE Maywood, Mo. DATE Jan 8 1940
 19. FUNERAL DIRECTOR C. H. Chambers
 (ADDRESS) Maywood, Mo.
 20. FILED Jan 6 1940 Vertude Lee
 Local Registrar.

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.

STATEMENT BY LICENSED EMBALMER

I, A. H. Chambers, Licensed Embalmer No. 3766

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

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed A. H. Chambers

Licensed Embalmer No. 3766

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.)