

Registration District No.

Primary Registration District No.

267

54098

Registrar's No.

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

1. PLACE OF DEATH:

(a) County *Tyarkliss Co*
 (b) City or town *Rural* (If outside city or town limits, write "RURAL" and name of township)
 (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 (Specify whether

In this community *8 mo. 23 day s.* years, months or days)3. (a) PRINT
FULL NAME*Virginia Mae Johnson*

3. (b) If veteran,

name war

3. (c) Social Security

No. *no*4. Sex *Female*5. Color or race *W*6. (b) Name of husband or wife *Wm*6. (a) Single, widowed, married, divorced *Wm*

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE: Years *8*Months *23*Days *0*

If less than one day

hr. *0* min. *0*9. Birthplace *Tyarkliss Co*

(City, town, or county)

(State or foreign country)

10. Usual occupation *house*11. Industry or business *house*12. Name *Oscar Johnson*13. Birthplace *Tyarkliss Co* (State or foreign country)14. Maiden name *Wm* (State or foreign country) *Wm*15. Birthplace *Tyarkliss Co* (State or foreign country)16. (a) Informant *Oscar Johnson*(b) Address *St. Clair Mo*17. (a) Burial *Burial* (b) Date thereof *June 1 1940*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *St. Clair Cemetery*18. (a) Signature of funeral director *Spencer Mitchell*(b) Address *St. Clair Mo*19. (a) Date received local registrar *May 9, 1940* (b) Registrar's signature *W. H. Duckworth*

(Dated received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Tyarkliss*

(c) City or town *Rural* (If outside city or town limits, write "RURAL")(d) Street No. *Central Twp.* (If rural, give location)(e) If foreign born, how long in U. S. A.? *✓* years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *20* year *1940* hour *8 11/12* minute *01* M.21. I hereby certify that I attended the deceased from *May 21*, 1940, to *May 22*, 1940, that I last saw *Wm* alive on *May 28*, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death

Acute Endocarditis

Due to

Due to *Suffocation*

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. (a) Type of place *While at work* (b) Means of injury *W. E. Kitchell*(c) M. D. or other *W. E. Kitchell*Address *St. Clair Mo* Date signed *May 9, 1940*

Duration

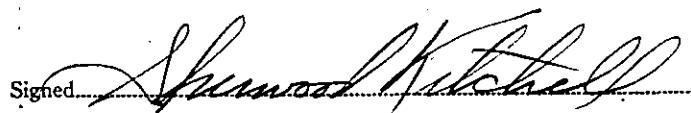
PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

Signed.....



Licensed Embalmer No. 3873

P. O. Address. 112 Clarendon

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.