

Registration District No. JUL 15 1940 Primary Registration District No. 6051 Registrar's No. _____

1. PLACE OF DEATH
(a) County Schuyler Prairie Twp
(b) City or town Near Greencity MO
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

8. (a) PRINT FULL NAME Eliza Ella Johnson
8. (b) If veteran, name was None
8. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Name of husband or wife Married 6. (c) Age of husband or wife if alive deceased years
Johnson 28 1875
7. Birth date of deceased Mar 28 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 3 20 ✓ hr. min.

9. Birthplace Schuyler Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Route Work

11. Industry or business _____
12. Name Henry Eaglesong
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
14. Maiden name Frances Shost
15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Helen Johnson
(b) Address Wrensalls, Mo.

17. (a) Burial (b) Date thereof 7-10-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Town Cemetery

18. (a) Signature of funeral director Wm. H. West
(b) Address Greencity MO

19. (a) 7-9-1940 (b) J. J. Torres - Olive T. Torres
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 8
year 1940 hour 7 PM minute 5 M.

21. I hereby certify that I attended the deceased from Oct 1939, to July 8 1940
that I last saw her alive on July 8 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema
Duration 1 year

Due to Pneumonia June 1939

Due to Pneumonia June 1939

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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?

718 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature O. P. Green (M.D. or other) J. J. Torres
Address Greencity Date signed 7-9-1940

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

110a

RECEIVED

District Health Officer No. 10

District File Number 7-40-3427 1395

Date Filed JUL 10 1940

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 Myself

Registered Apprentice No. _____

working under my personal supervision.

Signed Wm N West

Licensed Embalmer No. 2882

P. O. Address Lucency M

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22945**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **806**

Primary Registration District No. **6057**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Schuyler**
(b) City or town **Prarie T.P.**
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Eliza Ella Johnson**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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 **65** Months **3** Days **10** 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)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **Empyemia** Duration

Pneumonia in June
Due to.....

1939
Due to..... **Labar Pulmonary**

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

Major findings: Of operations..... **108**

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. Signat..... (M-D. or other)

Address **Green City** Date **1940**

SUPPLEMENTARY

S-22945