

No. 2
17-3
X23159

REC'D OCT 18 1940
6 8 8

Registration District No. _____

Primary Registration District No. 3032

Registrar's No. 276

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2021 N. Washington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis

(c) City or town Sedalia
(If outside city or town limits, write "RURAL")

(d) Street No. 2049 N Washington
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Georgia Johnson

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

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm Johnson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 3 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>11</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace Wichita Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name George Silvers

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Jewell Wager

(b) Address 260 N. Washington

17. (a) Burial (b) Date thereof 9-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo

18. (a) Signature of funeral director A. D. Ferguson
(b) Address Sedalia

19. (a) 9/12/40 (b) Miss Harry Sneed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9/9 day _____ year 1940 hour 11:25 minute _____ M.

21. I hereby certify that I attended the deceased from 9/9 - 10/9/40 to 9/9 - 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure

Due to _____
Due to _____

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? _____

23. Signature A. D. Ferguson (M. D. or other) _____
Address _____ Date signed 12/10-40

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

MOTHER FATHER

2 D D A

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-11-40

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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32862

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Pettis
(b) City or town Warsaw
(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
In this community _____ years, months or days (Specify whether

3. (a) PRINT FULL NAME Georgia Johnson

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

4. Sex F 5. Color Cal 6. (a) Single, widowed, married, divorced W

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 49 Months 11 Days 21 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

20. DATE OF DEATH Month 9 day 9
year _____ 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.

Immediate cause of death _____

Due to _____

Due to _____

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? _____ (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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTAL REPORT
Heart failure
Myocardial infarction
92 W

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

