S. No. 2
-4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42014

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 338

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

4
2
2

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital no 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution yes (Specify whether
In this community 3 months and 11 days 3
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Chariton.
(c) City or town Keytesville
(If outside city or town limits, write "RURAL")
(d) Street No. County Infirmary.
(If rural, give location)
0
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Susie Johnson.
3. (b) If veteran, name war
3. (c) Social Security No. none
4. Sex Female
5. Color or race colored
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
65 approx			..... hr. ..... min.

9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation none 0
11. Industry or business 7
FATHER
12. Name Unknown 7
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant County Court
(b) Address Chariton Co. Keytesville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Grounds
18. (a) Signature of funeral director C. C. Thomas
(b) Address 302 Morphet St Fulton Mo
19. (a) Dec 16 1940 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11
year 1940 hour 1.05 P.M. minute ..... M.
21. I hereby certify that I attended the deceased from Aug 27, 1940, to Dec 11, 1940;
that I last saw her alive on Dec 11 40, 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute purulent endometritis	
Due to Broken down adenoma of uterus	
Due to	
Other conditions (Include pregnancy within 3 months of death) 55 P	
Major findings: Of operations	
Of autopsy Acute purulent endometritis	

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) no
(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 Forrest Thomas (M. D. or other)
Address State Hospital no 1 Fulton Mo Date signed 12/16-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.