MAY 9 1941

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

15766
Do not use this space.

1. PLACE OF DEATH
(a) County St Francois Registration District No. 224
(b) Township St Francois Primary Registration District No. 4465 Registered No. 1035
(c) City Flat River (d) Street No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Luella Johnson
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 1
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married 1
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. H. Johnson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6th 1869
7. AGE YEARS 71 MONTHS 7 DAYS 28 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 54

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alliance, Mo

FATHER
13. NAME John C. Leonard
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alliance, Mo

MOTHER
15. MAIDEN NAME Medora Nugent
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bollinger Co Mo

17. INFORMANT (ADDRESS) A. C. Johnson St Louis Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Yount, Mo DATE 5-5 1941
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Caldwell Bros Flat River Mo
20. FILED 5/22 1941 C B Frazier Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-3 1941

22. I HEREBY CERTIFY, That I attended deceased from May 1941, to 5-3 1941, I last saw her alive on 5-3 1941. Death is said to have occurred on the date stated above, at 9 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis	
Arteriosclerosis	
Hypertension	

Other contributory causes of importance: 93.2

Name of operation ..... 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? No
If so, specify
(Signed) C B Frazier M. D.
(Address) Flat River Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

BOM-1-12-38 1 X14628

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, above space should be left blank.

S. No. 2B
0—4-25-41
I X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15706

Registration District No. 774 Primary Registration District No. 4465 Registrar's No. 1035

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

1. PLACE OF DEATH:
(a) County St Francois
(b) ~~City or town~~ Flat River Twp
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Francois
(c) City or town Flat River
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lucille Johnson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
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 71 Months 7 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business at home
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 5-22-41 (Date received local registrar) (b) C B Farrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 3 year 1941 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 — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C B Farrar (M. D. or other)
Address Flat River Mo Date signed

SUPPLEMENTARY

S-15706