

FILED JAN 11 1943  
Registration District No. 374

Primary Registration District No. 6273

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

1. PLACE OF DEATH:

(a) County Worth

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

(c) Name of hospital or institution: 1 Satchel Temp  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth 115

(c) City or town Grant City, Mo 0  
(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 \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Katharine Johnson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25  
year 1942 hour 12 minutes 30 P.M.

21. I hereby certify that I attended the deceased from Feb - 1942  
10 1942 no. 12-25- 1942  
that I last saw her alive on Feb Dec 24 1942  
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race w

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Dr. William Johnson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 10 - 15 - 1853  
(Month) (Day) (Year)

Immediate cause of death hypertensive heart disease Duration 3 yrs

8. AGE: Years 89 Months 2 Days 10  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 93d

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

10. Usual occupation housewife

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Abraham C. Robertson

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

14. Maiden name Rosina Mash

15. Birthplace Gearey New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Sanford Pitney

(b) Address GRANT CITY, MO.

17. (a) burial (b) Date thereof 12/28/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant city, Mo.

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Grant city, Mo.

19. (a) Dec 28 - 1942 (b) Ardene Dearden  
(Date received local registrar) (Registrar's signature)

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) ✓ (Cause of injury)

23. Signature R. P. Hiss M.D. (M. D. or other) \_\_\_\_\_  
Address Grant City, Mo Date signed 12-26-42

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**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..... *Arch C. Dunfee* .....  
Licensed Embalmer No. *3252* .....  
P. O. Address. *Grant City, Mo* .....

**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.**