

FILED MAR 13 1943

Registration District No. 297

Primary Registration District No. 3057

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

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
404 North Main St.  
(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 Missouri (b) County Ray  
(c) City or town Dockery (rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 miles west  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARGARET ISABELLE JOHNSTON

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William Johnston 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 5, 1875  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>7</u>	<u>17</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Thomas McGill  
13. Birthplace Svanrick, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Ellis Patterson Turner  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant William Johnston

(b) Address Dockery, Missouri

17. (a) Burial (b) Date thereof 2-24-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dockery, Missouri

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

(b) Address Richmond, Missouri

19. (a) 7.4. (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 22nd  
year 1943 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from 6-15-41 19\_\_\_\_ to 2-22-43 19\_\_\_\_  
that I last saw her alive on 2-22-43 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 1 day

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

Other conditions Cancer of Ovary 1 yr  
(Include pregnancy within 3 months of death)

Major findings: Of operations H 9 a  
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)  
(c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) xx-43  
Address Richmond, Mo. Date signed 2-24

District Health Officer No. 8,

District File Number .....

Date Filed 3-12-43

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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, J. E. X.  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *J. E. X.*

Licensed Embalmer No. 2073

P.O. Address Richmond, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7391  
Registrar's No. 11

Registration District No. 297

Primary Registration District No. 3267

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Richmond  
(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)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Margaret J. Johnston

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

4. Sex S 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: July 5 1877  
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) Feb 24 1943 (b) Mrs. Chas W Sheppard  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 22  
Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_  
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 \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

MOTHER FATHER

SUPPLEMENTARY 22

