FILED FEB 11 1944

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

2981
Do not use this space.

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied.

1. PLACE OF DEATH
(a) County Harrison — Registration District No. 136
(b) Township Hamilton — Primary Registration District No. 5-498 — Registered No.
(c) City or Hamilton Twp near Hatfield
(d) Street No. ... 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 70 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 71 yrs. mos. ds.

2. PRINT FULL NAME John N Johnston
(a) Residence, No. Rural - near Hatfield, Mo. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Mary Ann Johnston

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22 1846

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	97	4	16	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
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) 1944
11. Total time (years) spent in this occupation 57

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada ?

FATHER
13. NAME Robert Johnston
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland ?

MOTHER
15. MAIDEN NAME Martha Foster
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NOT KNOWN

17. INFORMANT (ADDRESS) Emma Johnston Hatfield Mo.

18. BURIAL, CREMATION, OR REMOVAL Harrison Co. Mo.
PLACE Payne Cemetary DATE ...19...

19. FUNERAL DIRECTOR (NAME) Rollin White
(ADDRESS) Lamoni, Iowa.

20. FILED 1-14 19 44 Chas Adair
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 8 19 44

22. I HEREBY CERTIFY, That I attended deceased from Jan 2 1944, to death Jan 8, 19 44
last saw h... alive on ..., 19... Death is said to have occurred on the date stated above, at ...m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Right Lobar pneumonia (Senility)	

Other contributory causes of importance:
Fourth and 5th right ribs cracked from fall; January 1, 1944

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. M. Propst, M. D.
(Address) Bethany, Missouri

112 2.

(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.....

W. A. Marsh, Registered Apprentice No.....

working under my personal supervision.

Signed Rollin White

Licensed Embalmer No. 3895

P. O. Address Lamoni, Iowa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Rural (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 John Johnston
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M
5. Color or race W
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 Aug. 22 18[illegible] (Month) (Day) (Year)
8. AGE: Years 97 Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Canada (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8 year 1944 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 L. Lobar Pneumonia — Senility
Due to 4th & 5th right ribs
Due to Cracked from fall 1-1-44
Other conditions (Include pregnancy within 3 months of death) 1860a 18
Major findings:
Of operations
Of autopsy

Duration

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) Accident
(b) Date of occurrence 1-1-44
(c) Where did injury occur? Harrison Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Front steps of home (Specify type of place)
While at work? No (e) Means of injury Slipped on steps
23. Signature C. M. Perpet (M.D. or other) DO
Address Bethany Mo. Date signed 2/16/44

SUPPLEMENTARY