

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 5

1. PLACE OF DEATH:

(a) County HENRY
(b) City or town CLINTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
511 S. CARTER ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NONE
(Specify whether
In this community 54 YRS. OF LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. 511 S. Carter St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MARY ELIZABETH JOHNSON

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

4. Sex F. 5. Color or race W 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife H. S. JOHNSON 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased March 15 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 9 20 hr. min.

9. Birthplace ADELL IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business _____

MOTHER FATHER { 12. Name THOMAS SHAGLEY 9
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant H. S. JOHNSON
(b) Address Clinton, Mo.

17. (a) Rural (b) Date thereof 1-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director H. S. JOHNSON

(b) Address Clinton, Mo.

19. (a) Jan 9 1944 (b) Georgia Kitcher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5th.
year 1944 hour 9:30 minute 5 P. M.

21. I hereby certify that I attended the deceased from September 30, 1939 to Dec 5, 1944.
that I last saw him alive on Dec 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary (Bronchial) hypertrophy Duration 3 days

Due to _____

Due to _____

Other conditions Diabetes 6-1
(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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph B. Mill (M. D. or other) MD
Address Clinton, Mo. Date signed 1-7-44

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

RECEIVED

District Health Officer No. 71

State File Number 1-44-147

Date Filed 2-9-44

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 J. J. Vaisant

Licensed Embalmer No. 3779

P. O. Address Clinton 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 187

Primary Registration District No. 3023

Registrar's No. 01

1. PLACE OF DEATH:

(a) County Henry Clinton

(b) City or town _____
(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

3. (a) PRINT FULL NAME Mary E. 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, married

6. (b) Name of husband or wife H.S.

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May 15 1881
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>9</u>	<u>2</u>	_____ min.

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

10. Usual occupation _____

11. Industry or 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) _____ (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day _____
year 1944 age _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, 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)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

3011