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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7704

FILED MAR 8 1944

Registration District No. 19184 Primary Registration District No. 4310 Registrar's No. 46

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Brewer
(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 Mo (b) County Macon
(c) City or town Brewer
(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 KAREN JOHNSON LARIER

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married. Divorced
6. (b) Name of husband or wife Robert J 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years Months Days If less than one day
89 3 17 _____ hr. _____ min.

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

10. Usual occupation Cement

11. Industry or business _____

12. Name John Shain

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

14. Maiden name Elizabeth Hatfield

15. Birthplace Macon Mo
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Johnson

(b) Address Brewer Mo

17. (a) Burial (b) Date thereof 2-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home _____

18. (a) Signature of funeral director W. Edwards

(b) Address Brewer Mo

19. (a) 3-4-44 (b) Winnie J Rowland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1944 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan. 27, 1944 to Feb. 25, 1944
that I last saw her alive on Feb. 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis

Due to Chronic Interstitial nephritis

Due to Arteriosclerosis

Other conditions Edema
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 131a

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 Dr. E. L. Wood

Address Brewer Mo Date signed 2/26/44

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

1289

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 3-44-478

Date Filed MAR 7 1944

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 [Signature]

Licensed Embalmer No. 1961

P. O. Address Devis, 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.